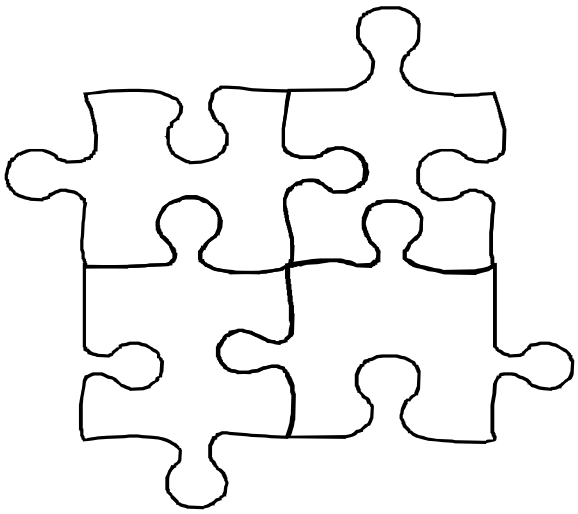
COMMUNITY SERVICES DATA SYSTEM
STATE FISCAL YEAR 2008
DATA REQUIREMENTS AND INSTRUCTIONS



SFY08 July 1, 2007 Through June 30, 2008

Revision 2: October 2007

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FAMILY AND SOCIAL SERVICES ADMINISTRATION
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FAMILY AND SOCIAL SERVICES ADMINISTRATION

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PURPOSE OF DOCUMENT

This document contains reporting requirements for HOOSIER ASSURANCE PLAN PROVIDERS, for State Fiscal Year (SFY) 2008 (July 1, 2007 through June 30, 2008) for ALL consumers who qualify for the Hoosier Assurance Plan (HAP), along with those SED consumers under the DAWN Project who do not qualify for the Hoosier Assurance Plan.

If your agency sub-contracts for any or all of these services, your agency is responsible for reporting the information for those services from your sub-contractor(s). It is not the responsibility of your sub-contractor(s).

The purpose of this reporting package is to provide the Division of Mental Health and Addiction with contract information regarding consumer eligibility/registration, performance indicator data, initiation/verification of reimbursement claims, consumer service and revenue information, as well as meeting Federal Minimum Data Set (MDS) requirements for substance abuse and mental health services.

It is recommended that each individual read this document in its entirety.

SFY 2008 MAJOR CHANGES

There are several significant changes to the collection of data through the Community Services Data System for state fiscal year 2008 that will affect service delivery and data reporting.
This 2nd revision primarily contains clarification of wording and system requirements. The most significant changes are as follows:

Service Delivery
Except for the "carve-outs" (ACT, SOF Agreements, Gambling, Deaf Services, and Methadone), payments to providers are no longer for specific consumers. This allows consumers to receive services from the provider(s) of their choice and allows the provider(s) to submit registration/demographic/outcome, encounter, and revenue data for any consumer being served. The changes also allow consumers to receive services from multiple providers simultaneously.

Annual "enrollments" have been eliminated. Each consumer will be "registered" in CSDS. Tracking of services and persons served will utilize an episode of care methodology. An episode of care is defined by an admission date and a discharge date. For SFY 2008, the admission date will be the date of the initial assessment for SFY 2008 (HAPI-A for adults and CANS for youth). The discharge date will be the date of separation from service. An episode of care has no time limitations other than it must be longer than one day. (A consumer may not be admitted and discharged on the same day.)

Adult Assessments
All adults must have a single HAPI-A completed for SFY 2008. The HAPI-A may be administered between April 2007 and June 2007 for use in SFY 2008. This will allow providers to spread the workload for both assessment and reassessment. In addition to the HAPI LOF scores and agreement identifiers, providers are to submit data about the following outcomes for adults to be used for performance measurement as the "initial assessment":

- ACT – adults only
- Criminal Activity
- Detailed-Not in Labor Force
- Employment
- Illness Management and Recovery
- Integrated Dual Diagnosis Treatment
- Living Arrangement
- Substance Usage data (primary, secondary and tertiary substances, route of ingestion, frequency of use/intake, and age at first use/intoxication)
- Supported Employment
- Supported Housing

Reassessment is required at the time of discharge and every 180 days between admission and discharge. For adults the reassessment requires reporting on the outcomes listed above. LOF scores are not required for reassessments.

Multiple episodes of care for a consumer will require reporting of admission assessment and reassessment data. However, the HAPI-A is only required once during SFY 2008.

Child and Adolescent Assessments
The HAPI-C Assessment Tool for youth is no longer required beginning in SFY 2008. This assessment is being replaced with the Child and Adolescent Needs and Strengths (CANS) assessment tool.

As of July 2007, all children and adolescents registration/demographic/outcome data must be entered in CSDS and CANS results must be entered in the Indiana Behavioral Health Assessment System (IBHAS) database.

The initial CSDS Registration/Demographic/Outcome Report for youth will require completion of **all** data fields which may include the following but excluding the LOF Factors:

- Criminal Activity
- Detailed-Not in Labor Force (Applicable only if employment is reported as "4")
- Employment
- HCBS – PRTF Waiver – youth through age 21 only
- Living Arrangement

- Race
- Roles
- SOC
- Substance Usage data (primary, secondary and tertiary substances, route of ingestion, frequency of use/intake, and age at first use/intoxication)

All youth, those with serious emotional disturbance (SED) and with addiction (CA), are required to have a CANS assessment administered by **a certified CANS user** and the data submitted to DMHA at the beginning of SFY 2008. Data submission for the CANS is **not the same as** CSDS data reporting. Only staff certified in the use of the CANS may use the tool; all CANS data reported must have the certified user's identification number.

Reassessments using the CANS are required at discharge and at least every 180 days of continuous services to the youth. More frequent assessment is required if a more intense level of service is being requested. **A separate manual for using the CANS is available at: http://www.in.gov/fssa/mental/canstools.htm**

Each reassessment of a youth requires re-submission of the Registration/Demographic/Outcome Report with **all** data fields completed except the LOF Factors: LOF fields for HAPI-C assessments in the Registration/Demographic/Outcome Report should be sent in with empty values or blank fields.

Data Reporting

Initial reporting and reassessment reporting will utilize the same data set, which has been named the Registration/ Demographic/Outcome Report. (See page 5) There is no longer a separate record layout for Reassessment.

Encounter/Service Reporting requires that each encounter be reported. **Bundling** of encounters into one report for the month (or other time frame) is no longer permissible except for procedures/services which are intended to be 24-hours (residential and inpatient). For 24-hour programs, the encounter/service report may have a begin date and end date for the month in which services were provided. If there is an interruption in the 24-hour service (consumer is discharged and readmitted in the same month) each episode must be reported with beginning and end dates.

The other major changes to CSDS data fields are specific to Reason Code and episodes of care (meaning each admission through discharge). The following pages contain some questions submitted to DMHA regarding changes in CSDS with answers provided by DMHA.

COMMUNITY SERVICES DATA SYSTEM QUESTIONS FOR SFY 2008

1. With the changes for FY 08, will we continue to report months where there were no encounters, since the consumer may be receiving services at another center--I presume we continue to do so until we designate the chart as closed?

   Yes, you should continue to submit an encounter record for each active consumer each month

2. Which consumers are getting rolled over for FY08. Is it all "active" consumers enrolled in FY07 or just those enrolled April - June? Is it adults and kids?

   From the multiple discussions about whether or not to roll over any data from FY 07 into FY 08, we have decided not to do this. As of July 2007, each provider will need to submit the Registration/ Demographic/Outcome record for each consumer being served, regardless of age. For adults, the HAPI-A LOF scores may be obtained for FY 08 beginning in April 2007 (see next two paragraphs). For children, the CANS will be required for all youth served beginning in July.

   Any adult consumer who the provider believes will be continuing in services as of July 2007 may be assessed, reassessed in April, May, or June with the HAPI-A. When the provider submits the Registration data set in July, the LOF scores from these HAPI-A's may be submitted with the Registration data set. **The Assessment Date (field 16) should correspond to the actual date of the HAPI-A administration.**

   Providers are encouraged to spread the assessments over these months in order to avoid having to do so many assessments in July/August -- and reassessments all being due to January/February. For those consumers with a HAPI-A between April - June 2007, the HAPI-A does not have to be done in fiscal year 2008.

3. Are we expected to do registration data (including a HAPI-A or CANS) on all of our active consumers again in FY08?

   A registration data set is expected for all consumers served in FY 08. (See above response.) The HAPI-A LOF scores are reported on the Registration/Demographic/Outcome record. (Also see above about when the LOF is obtained.) The CANS data goes into a different database and is not part of the Registration/Demographic/Outcome record. Information is being shared with all providers about submitting CANS data. If you have not received the information about Importing/Exporting data from/ to the Indiana Behavioral Health Assessment System (IBHAS), please contact John Dwenger (john.dwenger@fssa.in.gov) and he will send the document to you.

4. When we submit a reassessment (outcomes data) I understand that we send in the registration file but for all the fields other than outcomes data, do we send blanks or do we send old data or are we expected to provide new data each time (i.e. financial data, diagnosis, disability, Medicaid indicator, funding indicator, etc)?

   Each field in the record should have some data. It may be the old data or it may be updated data. We do not know how each provider's database works, but for those who have communicated with us, this is a basic set of data held in the database and updated by the provider as needed. It is also a subset of other data collected by the provider. So submitting all data in this particular record layout may be a routine that runs at some point in time and is batched to CSDS.

5. We are wondering about financial eligibility. We usually assess that at the time of enrollment in the fiscal year. When are you expecting us to do that on an on-going basis? A large number of our consumers are chronic and have been with us for years so once we register them you will get financial information and I know you want reassessment information every 6 months but when are their finances ever reviewed again for eligibility?

   This is based on your business practices. DMHA does not have a mandate that you reassess financial

status annually. However, the expectation of DMHA is that each provider will ensure that persons in HAP are at or below 200% of the federal poverty level.

6. What distinguishes a Reassessment record from a Registration record? Is it the Transaction Code? There is not a separate record layout for a Reassessment in the Draft Manual.

   Beginning in FY 08, there will not be a separate reassessment record layout. We are adding one field to the existing Enrollment Record Layout (Field 79 -- Reason Code) which will tell the system that the submission is a reassessment. A Reason Code "0" is to be used for the first submission of the Registration record for each episode of care.

7. Beginning July 1 2007, what should the value of Reason Code (F79) be in a first time submission of a Registration/Demographic/Outcome (RDO) record for the purpose of registration?

   DMHA has added Reason Code "0" for use whenever a Registration/Demographic/Outcome record is submitted to activate or re-activate the consumer in CSDS. Use of this code will begin an episode of care on the date given in Field 6 (Registration Date).

8. Consumers enrolled in FY07 with Enrollment Dates March through June 2007 will require Registration in FY08 via RDO records submitted sometime after July 1 with Reason Code = 9. Is this correct? LOFs do not need to be in these records. Is this correct?

   A Registration/Demographic/Outcome record is required for each consumer served July 1, 2007 and thereafter. These records will use Reason Code "0". LOF scores for adults that were obtained in April, May or June 2007 can be resubmitted on the Registration/Demographic/Outcome record and the date of the actual assessment may be entered in Field 16 (Assessment Date).

9. I have registered a consumer in FY08 with a Low Functioning Agreement ID (F12) (example MI1). Prior to discharge and prior to 180 days I learn this consumer has a newly uncovered substance abuse diagnosis. I want this consumer to be recognized by the state as a substance abuse consumer. How do I update the consumer's registration to reflect the change to his Agreement ID?

   Re-submit the Registration/Demographic/Outcome record using Transaction Code "1", Reason Code "9" and the new Agreement Identifier. All other fields in the record will likely be the same as originally submitted.

10. Another MHC registers a consumer, but then the consumer becomes active at a second MHC. The second MHC notices the consumer is active in CSDS. Is the second MHC required to submit a RDO with LOF scores?

    The second provider will need to submit a Registration/Demographic/Outcome record for the consumer in order to receive credit for serving the consumer. For fiscal year 2008, each provider that registers an adult consumer will need to complete the HAPI-A.

11. Can you issue a number for HAP in the cases where the consumers are foster children and the foster parents are not given their SS#?

    Recently, the Department of Child Services issued a memo to the local offices restricting the sharing of social security numbers. However, the last four digits of the social security number may be released. If you admit a child and the caregiver does not know the social security number, you may contact the local child services office and ask for the last four digits. If this does not work, please notify DMHA. In some cases as a last resort, DMHA can assign numbers for you.

12. How and when do we give you HAP information obtained from April 2007 thru June 2007? Do we have to send it now and on July 2?

    You should submit an enrollment for any new consumer for the remainder of fiscal year 2007. HAPI-As completed during April through June for persons already enrolled should be reported with the first

registration in fiscal year 2008.

13. Since the registration/ outcome record is now a single file instead of separate enrollment and reassessment, does that mean we can just use commas for the fields already submitted when consumers are "registered". This is assuming none if that data has changed. The outcome data set is much smaller so I just need to be clear on how the file should look going into CSDS.

    No. You will not use commas. The entire Registration/Demographic/Outcome record data set is to be submitted each time you report reassessment information.

14. There is no reason code of initial registration so I assume that field is left blank the first time around.

    DMHA has added Reason Code "0" for use whenever a Registration/Demographic/Outcome record is submitted to activate or re-activate the consumer in CSDS. Use of this code will begin an episode of care on the date given in Field 6 (Registration Date).

15. When will the FY08 test system be available on CSDS for testing purposes?

    The system will be available at the beginning of June 2007.

16. Since the CANS instrument is a separate system, how will we know it is time for a 180 day reassessment? How will this be tracking for compliance in CSDS or will you just look for the other outcome data to meet the 80% compliance?

    DMHA will be monitoring reassessments for youth during fiscal year 2008.

17. I'm being told that the people training super users on the CANS are telling them they don't have to do reassessments. The CSDS document says they do at discharge or every 180 days. Which is correct?

    This is absolutely incorrect. Evidently there is some misunderstanding. We have contacted the trainers who state that they are telling super users that reassessments are required. We will be issuing the manual for the Indiana Behavioral Health Assessment System (IBHAS) and will advise providers when it is posted.

18. If we post questions to the CSDS forum page is someone monitoring them? I noticed one out there from another center regarding FY08 changes.

    Yes. We are monitoring the CSDS forum page.

19. As we are looking at the processes for FY08 and trying to setup our system for tracking information for next year has a decision been made on how we are going to submit the registration information? Will we submit a registration date and a HAP Assessment date?

    Yes, both a registration data and an assessment date are included. Tracking when reassessments are due will be based on the actual assessment date provided.

20. Will the 180 day reassessment be pulled then from the HAP Assessment date or the CANS Assessment dates?

    DMHA will use the assessment date provided in the specific database – CSDS or IBHAS.

21. I'm also getting questioned as to when we can expect to receive the Consumer Letters for the HAP & CANS? Will the letter address those consumers that have the HAP assessment done in April – June?

    We are working on these letters. Will let you know more soon.

22. If the provider changes the diagnosis and this change results in a change in Agreement Identifier (MI1, MI5, etc.) can and should this information be updated in CSDS?

    Yes, the information should be updated in CSDS by submitting a Registration/ Demographic/Outcome record with Transaction Code 1 and Reason Code 9.

23. Can the provider continue to batch all Registration/Demographic/Outcome records for both the "carve-outs" and the non-carved out population groups?

    Yes. For the carve-outs, the Funding Indicator should be 1 if a payment is being requested. For all regular registrations, the Funding Indicator is 2 and for updated reporting for the carve-outs, the Funding Indicator is also 2.

24. What is the reason code for the initial registration?

    DMHA has added Reason Code "0" for use whenever a Registration/Demographic/Outcome record is submitted to activate or re-activate the consumer in CSDS. Use of this code will begin an episode of care on the date given in Field 6 (Registration Date).

25. Can encounter data be submitted as a daily bundle?

    Submitting data as a daily bundle should be the provider's business decision. Submitting data weekly or monthly is not acceptable. *(except for 24 hour programs)*

26. What if we register someone and they do not return for services?

    Consumers that do not return for services should be discharged according to your agency policies. The discharge must be reported to DMHA using CSDS.

27. A consumer is registered, receives services and discharged. Two months later, the consumer presents in need of services? When does the clock start for reassessment?

    Registration, encounter and discharge data are submitted for each episode of care. If a consumer presents for another episode of care, updated registration data must be submitted, but another HAPI does not have to be done. The Reassessment clock begins on the date the new episode of care begins.

28. Please clarify the definition of bundling data (for non 24 hour services). Our agency currently reports each encounter separately but submits only 1 report (containing all of the info on the separate encounters) at the end of the month. Is this ok or is this considered bundling? Do they need to submit separate encounters daily?

    If the current practice does not allow DMHA to know on what actual date an encounter occurred, then this is considered bundling of encounters. For example, some providers will submit encounter data at the end of the month that says the consumer received xx units of xx service/procedure beginning on the first of the month and ending on the last day of the month. This is bundled. For example, Johnny received 150 units of case management between 3/1/07 and 3/31/07. We do not know on what days Johnny actually received a service. We only know volume for the month.

    Within the Performance Measure Definitions, one measure (retention in treatment) requires that DMHA be able to count 3 different encounters on 3 different days during the month. With bundled encounter reporting, this calculation is not possible. Therefore, DMHA is requiring that encounters be reported by day except for 24 hour programs which may report by month. Multiple units may be reported together for a day (example: 16 units of case management on 3/14/2007) even if the units occur at different times during the day.

CSDS Questions Received Since First Printing

1. Regarding enrollments from April 1, 2007 through July 1, 2007, it is my understanding that anyone who has been enrolled through our center between these dates will not need a new enrollment as of July 1.

   That is not correct. All persons served in state fiscal year 2008 must be registered in CSDS. This includes both children and adults. Adults who were "enrolled" between April 1 and June 30, 2007 and had a HAPI-A completed and reported during that time do not need to have a new HAPI-A completed.

2. Did the CSDS website ever get changed to accept a "null value" in field #16 (assessment date) for children? There is no HAPI-A date to put in there for children.

   Yes, this problem was resolved.

3. Are LOF Factors required for children and adolescents?

   No, please note in the CSDS Manual that fields 23 through 28 have NULL values. These were the child/adolescent LOF fields in years previous.

5. If a person is registered by ABC MHC, then comes to DCE for addiction services and we register the individual, will both registrations show up in CSDS?

   Yes, the person can be registered by more than one provider simultaneously.

6. Will CSDS now show if the person's episode of care has ended in a location. Say ABC MHC discharged that person, will CSDS be able to give us that data?

   Yes, if the other provider has discharged the person before you submit your registration data, you will get a notice that the person was previously registered by x provider.

7. I though you said the 180 Day RDO should be based on the Registration Date. Am I mistaken?

   Actually, the 180 day reassessment RDO is based on the assessment date submitted with the first RDO. You would submit the second RDO for the first reassessment you have after July 1, 2007. The first RDO is just to get the year started. If the assessment date on that RDO is in April, May, or June 2007 because you have HAPI-A LOF scores from those months, your first 180 day reassessment is 6 or so months from the assessment date. Example:

   HAPI-A completed on May 16, 2007
   RDO submitted for fiscal year 2008 on July 10, 2007. Registration date is July 10, 2007 and assessment date is May 16, 2007.
   If the client is not discharged, the 180 day reassessment is due around November 16, 2007.

8. If a consumer's income increases after registration to above 200% poverty level, should this consumer be discharged from CSDS?

   During SFY 08, there would be no need to discharge from CSDS a consumer whose income is at or below 200% of poverty at the time of the first registration if the income exceeds the "HAP" limit during the same episode of care -- that is as long as services continue to be provided to the consumer. So the answer to your question is, no you do not have to discharge from CSDS based solely on income. If you do discharge the consumer for other reasons and the consumer returns for services after the discharge, you probably would not include the consumer in future data submissions if the income is still above 200% of poverty.

   Your question is one for which the answer might change in future years as we continue through the mental health and addiction transformation process. Therefore, we are putting it in what we call the parking lot for consideration in FY 2009 and beyond.

9. On the HAP and the 180 day outcome measures we are suppose to note whether someone is in supported employment and the amount they are working. In the past we have only included those people who were in our traditional supported employment program, but we are now wondering if we should be including people who are in IPS and TE through our grant.

   Another question, should those individuals who are on the ACT team receiving SE support through their vocational person on the ACT team be included. And (although it doesn't happen very often) if someone is receiving supported employment services through another community rehab provider should they be included?

   If a client is in ACT, do not include in SE also. IPS and TE should not be included as Supported Employment. The last question depends upon what the other provider is doing. SE is supposed to be the evidence-based practice as recognized by SAMHSA. We know that not all of the actual SE programs in the state meet all the criteria for the EBP but they are considered close enough to be counted.

10. What if we register someone and they do not return for services?

    Clients that do not return for services should be discharged according to your agency policies. The discharge must be reported to DMHA using CSDS.

11. A client is registered, receives services and discharged. Two months later, the client presents in need of services? When does the clock start for reassessment?

    Registration, encounter and discharge data are submitted for each episode of care. If a client presents for another episode of care, updated registration data must be submitted, but another HAPI does not have to be done.

    Reassessment clock begins on the date the new episode of care begins.

12. What distinguishes a Reassessment record from a Registration record? Is it the Transaction Code? There is not a separate record layout for a Reassessment in the Draft Manual for FY08.

    Registration/Demographic/Outcome Record Layout (Field 79 -- Reason Code) which will tell the system that the submission is a reassessment. Reason Code 1 indicates a reassessment.

13. When we submit a reassessment (outcomes data) I understand that we send in the registration file but for all the fields other than outcomes data, do we send blanks or do we send old data or are we expected to provide new data each time (i.e. financial data, diagnosis, disability, Medicaid indicator, funding indicator, etc)?

    Each field in the record should have some data. It may be the old data or it may be updated data. We do not know how each provider's database works, but for those who have communicated with us, this is a basic set of data held in the database and updated by the provider as needed. It is also a subset of other data collected by the provider. So submitting all data in this particular record layout may be a routine that runs at some point in time and is batched to CSDS.

TABLE OF CONTENTS

DIVISION OF MENTAL HEALTH AND ADDICTION and the COMMUNITY SERVICE DATA SYSTEM

OVERVIEW

The Family and Social Services Administration\Division of Mental Health and Addiction (DMHA) continues to use the Community Services Data System (CSDS) to collect data about consumers being served by the public mental health and addiction system in Indiana. The system utilizes electronic transmission of data and on-line access via the World Wide Web. The application supports both consumer tracking and claims reporting.

INTRODUCTION

A Registration is **qualifying as eligible for the Hoosier Assurance Plan** of the Division of Mental Health and Addiction for classes of services according to defined groups (i.e., Substance Abuse, Seriously Emotionally Disturbed, Seriously Mentally Ill, Addicted Women with Dependent Children or Pregnant, Co-Occurring Disorders, Compulsive Gambling Addiction, etc.). **Beginning in SFY 2008 an individual may be registered by multiple providers, each of which may submit data pertaining to demographic information, assessment, services provided, and revenue generated.**

WEB-SITE

The Community Services Data System web-site address is: **CSDS.FSSA.IN.GOV**
It is recommended that you use Internet Explorer version 5.0 or greater to access the site. For questions regarding authorization and use of the web-site, please contact Melissa Shriner at 317-232-7895 or melissa.shriner@fssa.in.gov

NOTE: Data will be locked August 16, 2008. Therefore, all data for SFY 2008 must be submitted by August 15, 2008

CRITERIA FOR ENROLLMENT (SFY 2008)

A consumer may be registered by the agency if he/she meets conditions in Group I, II and at least one (1) criteria in Group III:

GROUP I

Can be defined under at least one agreement code (see pages 15-19).

GROUP II

Whose residential condition is defined within one of the ninety-two counties within Indiana (see page 37)

GROUP III

The consumer:

(1) Is enrolled in MEDICAID
(2) Is enrolled in Food Stamps
(3) Is enrolled in TANF
(4) Can indicate being at or below 200% of poverty
(5) Can indicate that the difference between the income level and the consumer's "out-of-pocket" mental health and/or addiction treatment costs for the previous year equals less than 200% of poverty level
(6) Can indicate that payments on incurred gambling debt, subtracted from reported income in determining the enrollees income, equal less than 200% of the federal poverty level

HHS Poverty Guidelines

Size of Family Unit *	100% Poverty Annual *	200% Poverty Annual	250% Poverty Annual
1	$10,210	$20,420	$25,525
2	$13,690	$27,380	$34,225
3	$17,170	$34,340	$42,925
4	$20,650	$41,300	$51,625
5	$24,130	$48,260	$60,325
6	$27,610	$55,220	$69,025
7	$31,090	$62,180	$77,725
8	$34,570	$69,140	$86,425
For each additional person, add	$3,480	$6,960	$8,700

* SOURCE: *Federal Register*, Vol. 72, No. 15, January 24, 2007, pp. 3147-3148.

100% OF POVERTY ANNUAL is derived from the Department of Health & Human Services poverty guidelines for all states (except Alaska & Hawaii) and the District of Columbia. The 200% OF POVERTY ANNUAL was derived by doubling the 100% of Poverty Annual. The 250% OF POVERTY ANNUAL FOR TANF was derived by multiplying 100% of poverty by 2.5 (used for TANF only).

SUBMITTING DATA

Consumers may be registered manually or via batch submission through CSDS.

BATCH SUBMISSION

The following information is key to successfully submitting batch records. The following pages provide all the necessary file layouts.

Fields are comma delimited and all records are separated by a carriage return. Each batch record has a field defined for a transaction code to identify the kind of record being processed (1 for Add or 2 for Change).

Due to the nature of the batch submissions of data, it is important to note that all new REGISTRATION/ DEMOGRAPHIC/ OUTCOME records must be submitted and processed PRIOR to the submission of Encounter/Service and Revenue data. For instance, if a Registration file is submitted, and then a service file, it is possible for our system to process the service file prior to completing the Registration file, thus causing the service records to reject (Registration not found). Registrations should be submitted, and when a confirmation of the processing is returned, the remaining files should be submitted.

CRITICAL FIELDS

Critical Fields must be valid for records to be successfully submitted. The “ADD” column designates those critical fields for records being created in the CSDS. The “UPDATE” column identifies the key fields necessary to submit updates to records that already exist in the system. Deletes of registration records WILL NOT be accepted by batch submissions. A Provider cannot delete registrations once they are entered into the system. Deletion of registration records may be handled by the Division of Mental Health and Addiction, at the request of the Provider, by contacting Melissa Shriner at 317-232-7895 or melissa.shriner@fssa.in.gov. Revenue and Encounter/Service records cannot be updated by batch Submission but may be updated by using the on-line consumer enrollment screen. Deletion of Encounter and Revenue batch submissions can be accomplished by utilizing the “Delete Batch” button found on the Batch List screen.

FUNDING INDICATOR

DMHA, via CSDS will allow funding, per consumer (i.e., registration) for the carve-outs. Carve-outs include the following agreement types:

- Assertive Community Treatment (ACT)
- State Operated Facility (SOF)
- Special Services (SPL)
- Gambling (GAM)
- Methadone (SMO)
- Deaf. (DGM, DED, DMI, or DCA)

If funding is available, the consumers should be coded under Funding Indicator as a "1" (register this individual and request funds).

When registering consumers in these "carve-out" groups in CSDS, and funding is not available, please use Funding Indicator "2" (register this individual, but funds are not requested). **NOTE:** If, a Provider batches in more consumer records with a Funding Indicator of "1", than their contract allows, **the data system will reject all submissions within the population. These registrations will need to be changed on your next submission with the appropriate number of Funding Indicator "1" and all records over the contract limit with a Funding Indicator "2".**

To review the current balance(s), please log-on to CSDS. Select "**Reports**" and then select the report entitled "**MCP Contracts**".

For all consumers not in one of the six (6) "carve-out" groups, the funding indicator field on the Registration/Demographic/Outcome record will be Funding Indicator "2"

SUBMISSION EDIT

To complete processing on rejected record(s) the rejected record(s) should be corrected by using the Error Report detailing the error(s). Rejected record(s) can be re-submitted in subsequent submissions.

CORRECTING ERRORS

Errors appearing on the Error Report are classified as being either a critical [did not get stored in the Community Services Data System], or a non-critical [stored on the Community Services Data System]. For those records with critical errors, the record(s) must be re-submitted with the data corrected. For the non-critical errors, corrections can be made on-line, or by submitting the file with a transaction code of "2" (update), containing the changed/corrected data fields. Remember only those fields that you are wishing to correct are to appear in the comma-separated file, along with the key fields.

If you **BATCH submit Registration/Demographic/Outcome, Encounter/Service, or Revenue Records and you receive rejected records, you should ONLY re-submit the REJECTED records, not the entire batch.** If you re-submit the entire batch, the previous records will receive duplicated information. If you need further assistance or clarification please contact Melissa Shriner at 317-232-7895 or melissa.shriner@fssa.in.gov.

Updating Fields in the Registration/Demographic/Outcome Record

Fields in the Registration/Demographic/Outcome Record may be updated to correct errors. Updating

requires re-submission of the entire record set using Transaction Code 2 (Change).

DATA RECORD FORMATTING

REGISTRATION/DEMOGRAPHIC/OUTCOME RECORD LAYOUT

OVERVIEW

The first submission of this record will contain the registration and initial assessment data collected by the Provider **This same record layout is to be used for each reassessment and discharge with the appropriate reason code for the purpose of the submission.**

FREQUENCY OF SUBMISSION

This record can be received at any time. Edits will be executed immediately and the record will either be rejected or accepted.

FIELD	FIELD NAME	FORMAT RECOMMENDED	CRITICAL FIELDS	
			ADD	UPDATE
1	Provider Number	4	☒	☒
2	Primary Subcontractor	4	☒	☒
3	Transaction	1	☒	☒
4	Unique Identifier	16	☒	☒
5	Agency Individual Identifier	15		
6	Registration Date	YYYYMMDD	☒	☒
7	Date of Birth	YYYYMMDD	☒	
8	Gender	1	☒	
9	[NULL] no data or spaces between commas	[NULL] no data or spaces between		
10	Disability	2	☒	
11	Ethnicity	1	☒	
12	Agreement Identification	4	☒	
13	County of Residence	2	☒	
14	Diagnosis, Primary	6	☒	
15	Diagnosis, Secondary	6		
16	Assessment Date	YYYYMMDD	☒	
17	LOF Factor (1) (A)	3	☒	
18	LOF Factor (2) (B)	3	☒	
19	LOF Factor (3) (C)	3	☒	
20	LOF Factor (4) (D)	3	☒	
21	LOF Factor (5) (E)	3	☒	
22	LOF Factor (6) (F)	3	☒	

23	**[NULL] no data or spaces between commas**	**[NULL] no data or spaces between**		
24	**[NULL] no data or spaces between commas**	**[NULL] no data or spaces between**		
25	**[NULL] no data or spaces between commas**	**[NULL] no data or spaces between**		
26	**[NULL] no data or spaces between commas**	**[NULL] no data or spaces between**		
27	**[NULL] no data or spaces between commas**	**[NULL] no data or spaces between**		
28	**[NULL] no data or spaces between commas**	**[NULL] no data or spaces between**		
29	**Substance Abuse Item (N)**	**3**	☒	
30	**SOGS Level of Function**	**3**	☒	
31	**Deaf or Hearing Impaired**	**1**	☒	
32	**TANF Code**	**1**	☒	
33	**Food Stamps Indicator**	**1**	☒	
34	**Medicaid Indicator**	**1**	☒	
35	**Medicaid ID**	**12**	☒	
36	**Funding Indicator**	**1**	☒	
37	**Marital Status**	**1**	☒	
38	**Adjusted Family Income**	**6**	☒	
39	**Family Size**	**2**	☒	
40	**Source of Referral**	**1**	☒	
41	**Legal Basis of Commitment**	**1**	☒	
42	**Living Arrangement**	**1**	☒	
43	**Veteran**	**1**	☒	
44	**Education**	**2**	☒	
45	**Employment**	**1**	☒	
46	**Health Insurance**	**1**	☒	
47	**Co-dependent/Collateral**	**1**	☒	
48	**Prior SA Treatment Episodes**	**1**	☒	
49	**Needle Use**	**1**	☒	
50	**Number of Consumer's Children Receiving Care (Including childcare)**	**1**	☒	
51	**Pregnant**	**1**	☒	
52	**Substance, Primary**	**2**	☒	
53	**Route, Primary**	**1**	☒	
54	**Frequency, Primary**	**1**	☒	

55	**Age, Primary**	**2**	☒	
56	**Substance, Secondary**	**2**	☒	
57	**Route, Secondary**	**1**	☒	
58	**Frequency, Secondary**	**1**	☒	
59	**Age, Secondary**	**2**	☒	
60	**Substance, Tertiary**	**2**	☒	
61	**Route, Tertiary**	**1**	☒	
62	**Frequency, Tertiary**	**1**	☒	
63	**Age, Tertiary**	**2**	☒	
64	**Roles**	**2**	☒	
65	**ACT**	**1**	☒	
66	**SOC**	**1**	☒	
67	**HCBS – PRTF Waiver**	**1**	☒	
68	**Criminal Activity**	**2**	☒	
69	**American Indian or Alaskan Native**	**1**	☒	
70	**Asian**	**1**	☒	
71	**Black / African American**	**1**	☒	
72	**Native Hawaiian / Other Pacific Islander**	**1**	☒	
73	**White**	**1**	☒	
74	**Supported Employment**	**1**	☒	
75	**Integrated Dual Diagnosis Treatment**	**1**	☒	
76	**Illness Management and Recovery**	**1**	☒	
77	**Supported Housing Services**	**1**	☒	
78	**Detailed – Not in Labor Force**	**2**	☒	
79	**Reason Code**	**1**	☒	

NOTES:
Field 29 – Level of Function Factor (N) is a critical field only for the Initial (first) HAPI-A Assessments.
Field 30 – SOGS Level of Function is a critical field only if the Agreement ID Is GAM or DGM.
Field 35 – Medicaid ID is a critical field only if the Medicaid Indicator is “1”.
Field 41 – Legal Basis of Commitment is a critical field only if the Source of Referral is “7”.
Field 64 – Roles is a critical field for consumers age 17 and under.
Field 66 – SOC is critical field for consumers age 17 and under.
Field 67 – HCBS Waiver is a critical field for consumers age 21 and under and are enrolled in Medicaid.
Field 78 – Detailed-Not in Labor Force is a critical field only if the “Employment” is coded as “4”.

FOLLOW-UP DATA REPORTING REQUIREMENTS

Follow-up data includes the reporting of the consumer's Reassessment(s) data, Encounter/Service data, and Revenue data. Reassessment(s) data is reported by resubmitting **all fields in the Registration/Demographic/Outcome record** and updating the fields at the bottom of this page. **This is required for both adults and youth.**

NOTE: Failure to report Reassessment data, Encounter/Service data, and Revenue data, as outlined in the following sections below, WILL AFFECT YOUR PERFORMANCE MEASURES.

REASSESSMENT REPORTING REQUIREMENT

DMHA will require that 80% of your consumers will have either a Discharge reassessment or a 6 month reassessment and all required data, or a Discharge reported in CSDS.

The HAPI-C Assessment Tool (for youth) is no longer required beginning in SFY 2008. This instrument is being replaced with the Child and Adolescent Needs and Strengths (CANS) assessment tool that is **required** for all children meeting the HAP eligibility criteria. Reassessments using the CANS are required at least every 180 days of continuous services to the youth and more frequently if a more intense level of service is being requested or if services end (discharge). **CANS reassessments and CSDS reassessments are not the same thing. A separate manual for using the CANS is available at:** http://www.in.gov/fssa/mental/canstools.htm

The HAPI-A Assessment Tool is required for each adult served during SFY 2008. **HAPI-A scores collected between April 1, 2007 and June 30, 2007 may be reported on the first Registration/ Demographics/ Outcomes record submitted in SFY 2008.** When the Registration/Demographic/ Outcome record is submitted after July 1, 2007, provide the date of the record in field 6 (Registration Date) and the actual date of the HAPI-A in field 16 (Assessment Date).

CSDS reassessments for adults and youth are required after 6 months of treatment and/or upon discharge. The reassessment consists of reporting "Outcome Measures" by resubmitting the **complete** Registration/Demographic/Outcome data set with updated information on the consumer in the following areas:

- ACT
- Criminal Activity
- Detailed-Not in Labor Force (Applicable only if employment is reported as "4")
- Employment
- HCBS – PRTF Waiver – youth through age 21 only
- Illness Management and Recovery
- Integrated Dual Diagnosis Treatment

- Living Arrangement
- Race
- Roles – youth only
- SOC – youth only
- Substance Usage data (primary, secondary and tertiary substances, route of ingestion, frequency of use/intake, and age at first use/intoxication)
- Supported Employment – adults only
- Supported Housing

If a consumer is reported in CSDS with a Reason Code of "4"-Discharge, "5"-Prision, or "6"-Deceased, DMHA will not require that the Living Arrangement, Employment, Substances Useage data, etc. be updated since the consumer will be considered as "inactive" in CSDS. However, if information is available in the clinical record which can be used to update demographic and/or outcomes data for these consumers, submission of this reassessment information is encouraged.

If the consumer has completed treatment and is mutually discharged (Reason Code "3") at any point during the state fiscal year, submit a new Registration/Demographic/Outcome record for the consumer by using "0" for the LOF scores and also complete the required fields of Living Arrangement, Employment, Substance Usage data (primary, secondary and tertiary substances, route of ingestion, frequency of use/intake, and age at first use/intoxication), Roles, ACT, SOC, HCBS Waiver, Criminal Activity, Supported Employment, Integrated Dual Diagnosis Treatment, Illness Management and Recovery, Supported Housing, and, if applicable, Detailed-Not in Labor Force. Once a consumer is reported as Reason Code "3", the consumer will be considered as "inactive" in CSDS.

Please see the "Reason Code" definition on pages 30-31 for additional information regarding the use of field 79 (Reason Code).

If the consumer has been "discharged", "imprisoned", or "deceased", re-submit the registration/ demographics/ outcomes record for the consumer using "0" for the LOF scores or by leaving the field blank. Do not repeat assessment scores from previous assessments already reported in CSDS.

Please utilize the **Missing Assessment Report** in CSDS to see which consumers need to have Outcome Measures reported.

ENCOUNTER/SERVICE RECORD REPORTING REQUIREMENT

Encounter/Service Codes are listed in Attachment A of this document. This portion of the CSDS instruction manual is considered as a "work in progress" and will be updated throughout the year as new service codes are added or deleted to the list. If a code is not listed, the Provider should not report that code until DMHA has approved the code for CSDS. The Provider is to submit a written request to DMHA (Attn: Melissa Shriner) to have the new service code added. (Please note that DMHA, in partnership with the providers, plans to review all the procedure codes currently in use by the system during SFY 2008 with the expectation of reducing the number of procedure codes available for use. Therefore, any request for additional codes should include a justification for the addition.)

Encounter/service data is not to be **"bundled"** (that is, units from multiple days submitted as one encounter) for any non-24 hour services. For programs that provide 24-hour care (such as residential and inpatient programs), data may be reported for the month with begin and end dates being the first day of service in the month and the end date being the last day prior to the date of discharge from the program.

> Example: Consumer is in residence on August 1 and is discharged on August 17 – Begin date is 08/01/2007 and end date is 08/16/2007.
>
> Example: Consumer is admitted to program on August 13 and remains in residence on the last day of August – Begin date is 08/13/2007 and end date is 08/31/2007.

Encounter/Service data must be submitted monthly and on all active consumers. The Encounter/Service data is to be reported within **44 days of the end of the month in which the service occurred.**

> Example: All encounter/services provided to the consumer for the month of July should be reported to CSDS by September 12; all encounter/services provided in August should be reported to CSDS by October 13; all encounter/services provided in September should be reported to CSDS by November 13 etc…

Please utilize the **Missing Encounter Report** on CSDS to see which consumers are missing monthly service data.

Reporting of Procedure Code

If you report a Procedure Code (field 9) do not use zero "0" or decimated numbers such as 0.25 in the Encounter Units (field 10) and remember to include the Encounter Value (field 11), if possible.

If the Consumer Did Not Receive Service During the Month

Unless the consumer is discharged, imprisoned, or deceased, the Provider must still report a record for the month, even if encounter/services **did not** occur. To do this, report the "begin date" (field 4) of the month and the "end date" (field 5) of the month. Leave the procedure code blank (field 9) and report zero for the encounter unit (field 10) and encounter value (field 11). Please complete all other fields if updated information is available.

Example: **MAR19620606F8787** was enrolled on July 16, 2007. She did not receive services the month of November

Record submitted for example would include:

FIELD #	FIELD NAME	EXAMPLE
1	Provider Number	777
2	Transaction	1
3	Unique Identifier	MAR19620606F8787
4	Encounter Begin Date	20071101
5	Encounter End Date	20071130
6	Sub Provider Code	
7	Diagnosis Code 1	
8	Diagnosis Code 2	
9	Procedure Code	
10	Encounter Units	0
11	Encounter Value	0
12	Clinician Level	
13	3rd Party Billing Indicator	

If the consumer is discharged (mutual or otherwise), imprisoned, or deceased, this information will need to be reported in the Registration/Demographic/Outcome record, field **79 (Reason Code).** This data reporting will notify DMHA not to expect future encounter/service data.

Reporting of Billable and Non-Billable Services on the Encounter/Service Record

The Provider must report all billable and non-billable services provided to the consumer.

Excessive use of code 90899 (unlisted psychiatric service or procedure) is not sufficient. If the Provider is providing service(s) that cannot be defined by the other encounter/service code(s) listed, please contact Melissa Shriner at 317-232-7895 or melissa.shriner@fssa.in.gov so that the service code list can be updated to reflect those services that your agency is truly providing.

ENCOUNTER/SERVICE RECORD LAYOUT

OVERVIEW

This record contains Encounter/Service data collected by the Provider.

FREQUENCY OF SUBMISSION

This record can be received at any time **the consumer is registered in CSDS**. Edits will be executed immediately and the Encounter/Service will either be rejected or stored in the database. This frequency does NOT replace the contract terms for service information and submission criteria.

NOTE

Negative Units and Negative Values are allowed.

FIELD #	FIELD NAME	FORMAT RECOMMENDED LENGTH	CRITICAL FIELDS
1	Provider Number	4	☒
2	Transaction	1	☒
3	Unique Identifier	16	☒
4	Encounter Begin Date	YYYYMMDD	☒
5	Encounter End Date	YYYYMMDD	☒
6	Sub Provider Code	10	
7	Diagnosis Code 1	6	
8	Diagnosis Code 2	6	
9	Procedure Code	5	☒
10	Encounter Units	4	☒
11	Encounter Value	5	☒
12	Clinician Level	2	☒
13	3rd Party Billing Indicator	1	☒

REVENUE REPORTING REQUIREMENT

Revenue data is to be reported monthly for active consumers. The Revenue data is to be reported within 44 days of the end of the month.

> Example: All revenue received for the month of July should be reported to CSDS by September 12; all revenue received in August should be reported to CSDS by October 13; etc.

If revenue was not received during the month, report zero "0".

REVENUE RECORD LAYOUT

OVERVIEW

This record contains Revenue data collected by the Provider.

FREQUENCY OF SUBMISSION

This record can be received at any time **after the consumer is registered in CSDS**. Edits will be executed immediately and the Revenue record will either be rejected or stored in the database.

NOTE

Revenue amounts may be negative.

FIELD #	FIELD NAME	FORMAT RECOMMENDED LENGTH	CRITICAL FIELDS
1	Provider Number	4	☒
2	Revenue Posting Date	YYYYMMDD	☒
3	Transaction	1	☒
4	Unique Identifier	16	☒
5	Revenue, Medicaid (MRO)	5	☒
6	Revenue, Medicaid, Other	5	☒
7	Revenue, Medicare	5	☒
8	Revenue, Non-DMHA Federal	5	☒
9	Revenue, Non-DMHA State	5	☒
10	Revenue, County/Local	5	☒
11	Revenue, Other	5	☒
12	Revenue, 3rd Party Other	5	☒

Site review teams DMHA will continue to contract with a site review team, as in past years. The site review team will review the following areas: HAPI-A, Registration/Demographic/Outcome data, encounter/service data, revenue data, and reassessment data. If the data is not available in the CSDS for the site review team's use, a second audit may be required, and will be at the expense of the provider.

THINGS TO KEEP IN MIND

- ✓ The CSDS Web Address is CSDS.FSSA.IN.GOV
- ✓ If a PROVIDER submits more Funding Indicator "1" records than their contract allows (for ACT, SOF, SPL, GAM, SMO, DGM, DED, DMI, or DCA), the Data System will reject ALL consumers within a POPULATION if submitted by batch. Providers entering consumer data manually, through the input screens, will have the record rejected at the point that funding is no longer available
- ✓ All other registrations require the use of Funding Indicator "2". Only the carve-out groups in the above bullet may be submitted using Funding Indicator "1"
- ✓ For questions regarding funding, contact Christi Hickman 317-232-7918
- ✓ For data policy, procedure, use of this manual, and the CSDS, contact Melissa Shriner, 317-232-7895 melissa.shriner@fssa.in.gov

SERIOUSLY MENTALLY ILL ADULT
(MI)

DEFINITION

(A) The individual has a mental illness diagnosis under the Diagnostic and Statistical Manual of Mental Disorders, (DSM-IV), published by the American Psychiatric Association.

(B) The individual experiences significant functional impairment in two (2) of the following areas:

(i) Activities of daily living.
(ii) Interpersonal functioning.
(iii) Concentration, persistence, and pace.
(iv) Adaptation to change.

(C) The duration of the mental illness has been, or is expected to be, in excess of twelve (12) months. However, adults who have experienced a situational trauma do not have to meet the durational requirement of this clause; **AND**

(D) In the professional opinion of the clinical staff, the person is considered to be Seriously Mentally Ill.

CHRONICALLY ADDICTED
(SA or CA)

DEFINITION

(A) The individual has a Substance-Related Disorder in DSM-IV.

(B) The individual experiences significant functional impairments in two (2) of the following areas:
(i) Activities of daily living.
(ii) Interpersonal functioning.
(iii) Ability to live without recurrent use of chemicals.
(iv) Psychological functioning.

(C) The duration of the addiction has been in excess of twelve (12) months. However, individuals who have experienced amnesic episodes (blackouts), or have experienced convulsions or other serious medical consequences of withdrawal from a chemical of abuse, or who display significant dangerousness as a result of chemical use, do not have to meet the durational requirement; **AND**

(D) In the professional opinion of the clinical staff, the person is considered to be Chronically Addicted.

CHRONICALLY ADDICTED
WOMAN WITH DEPENDENT CHILDREN OR PREGNANT
(SW or AW)

DEFINITION

(A) The individual shall meet the definition of Chronically Addicted; **AND**

(B) Have dependent children receiving child care, or be pregnant at the date of registration

OR

(C) Women who are attempting to regain custody of their children.

CO-OCCURRING DISORDERS
(CM)

DEFINITION

(A) The individual has a substance-related disorder in DSM-IV in the following categories: 303.xx to 305.xx (except 305.10 or 305.90) or 291.xx or 292.xx. **AND**

(B) The individual has a mental illness diagnosis under DSM-IV of 295.xx to 298.xx.

(C) The individual experiences significant functional impairments in two (2) of the following areas:
- (i) Activities of daily living.
- (ii) Interpersonal functioning.
- (iii) Ability to live without recurrent use of chemicals.
- (iv) Psychological functioning.

(D) The duration of the addiction has been in excess of twelve (12) months. However, individuals who have experienced amnesic episodes (blackouts), or have experienced convulsions or other serious medical consequences of withdrawal from a chemical of abuse, or who display significant dangerousness as a result of chemical use, do not have to meet the durational requirement; **AND**

(E) The duration of the mental illness has been, or is expected to be, in excess of twelve (12) months. However, adults who have experienced a situational trauma do not have to meet the durational requirement of this clause; **AND**

(F) In the professional opinion of the clinical staff, the person is considered to be both seriously mentally ill and chronically addicted.

SERIOUSLY EMOTIONALLY DISTURBED CHILDREN
(LESS THAN 18 YEARS OF AGE)
(SED)

DEFINITION

(A) The child has a mental illness diagnosis under DSM-IV.

(B) The child experiences significant functional impairments in at least one (1) of the following areas:

- (i) Activities of daily living.
- (ii) Interpersonal functioning.
- (iii) Concentration, persistence, and pace.
- (iv) Adaptation to change.

(C) The duration of the mental illness has been, or is expected to be, in excess of twelve (12) months. However, children who have experienced a situational trauma, and who are receiving services in two (2) or more community agencies, do not have to meet the duration requirement of this clause; **AND**

(D) In the professional opinion of the clinical staff, the child is considered to be Seriously Emotionally Disturbed.

COMPULSIVE GAMBLING ADDICTION
(GAM)

DEFINITION

(A) An individual who meets criteria for Axis-I diagnosis of pathological gambling as set out in the DSM-IV, Diagnosis 312.31, Pathological Gambling; **AND**

(B) The individual continues gambling behavior despite repetitive harmful consequences.

Note: Gambling requirements:

The South Oaks Gambling Screen (SOGS) is a screening instrument to assess the need for gambling treatment. Consumers completing the SOGS are to be given two scores for each question; a lifetime score and a score for the past twelve months. Consumers scoring more than a five for the past year on the scored questions may preliminarily be considered pathological gamblers. Consumers scoring three or more for the past year on the scored questions may preliminarily be considered problem gamblers.

Following completion of the SOGS, consumers are to be assessed for the DSM-IV criteria for gambling. Consumers must meet five of the ten criteria for the past year to be a pathological gambler, and must meet three or more criteria for the past year to be considered a problem gambler.

Please be aware that reporting a SOGS score of 2 or less is not acceptable and the consumer shall not be assigned under the GAM and DGM agreement types in CSDS.

METHADONE ONLY
(SMO)

DEFINITION

(A) A person who meets the diagnostic criteria of being Chronically Addicted; **AND**

(B) is determined to need methadone maintenance.

DEAF CHRONIC ADDICTION (Hard Of Hearing)
(DCA)

DEFINITION

(A) A person who meets the diagnostic criteria of being Chronically Addicted; **AND**

(B) meets the definition of Deaf/Hearing Impaired.

DEAF SERIOUSLY MENTALLY ILL (Adults) (Hard Of Hearing)
(DMI)

DEFINITION

(A) A person who meets the diagnostic criteria of being Seriously Mentally Ill; **AND**

(B) meets the definition of Deaf/Hearing Impaired.

DEAF SERIOUSLY EMOTIONALLY DISTURBED (Children) (Hard Of Hearing)
(DED)

DEFINITION

(A) A person who meets the diagnostic criteria of being Seriously Emotionally Disturbed; **AND**

(B) meets the definition of Deaf/Hearing Impaired.

DEAF GAMBLING (Hard Of Hearing)
(DGM)

DEFINITION

(A) A person who meets the diagnostic criteria of Compulsive Gambling Addiction; **AND**

(B) meets the definition of Deaf/Hearing Impaired.

Note: Gambling requirements:

The South Oaks Gambling Screen (SOGS) is a screening instrument to assess the need for gambling treatment. Consumers completing the SOGS are to be given two scores for each question; a lifetime score and a score for the past twelve months. Consumers scoring more than a five for the past year on the scored questions may preliminarily be considered pathological gamblers. Consumers scoring three or more for the past year on the scored questions may preliminarily be considered problem gamblers.

Following completion of the SOGS, consumers are to be assessed for the DSM-IV criteria for gambling. Consumers must meet five of the ten criteria for the past year to be a pathological gambler, and must meet three or more criteria for the past year to be considered a problem gambler.

Please be aware that reporting a SOGS score of 2 or less is not acceptable and the consumer shall not be assigned under the GAM and DGM agreement types in CSDS.

STATE OPERATED FACILITY
(SOF)

DEFINITION

(A) Consumer is pre-approved by the Division of Mental Health and Addiction as eligible as an SOF consumer—

(i) Consumer has been in a State Operated Facility for a specified time, **AND**

(ii) Consumer has been placed in the community by the Provider.

SPECIAL
(SPL)

DEFINITION

(A) Consumer has been identified and pre-approved by the Division of Mental Health and Addiction as requiring specialized services because of an exigent situation and the concurrent opportunity to demonstrate special models of service delivery.

ASSERTIVE COMMUNITY TREATMENT
(ACT)

DEFINITION

(A) Meets the definition of Seriously Mentally Ill Adult; **AND**

(B) Meets agency specific criteria which have been approved by DMHA. Examples of appropriate criteria are:

- Discharged patients from long-term hospitalizations.
- Consumers who have accumulated a high number of hospitalizations or have accumulated a large number of days hospitalized in the prior two years.
- Consumers who have repeated criminal justice/legal system involvement despite mental health intervention.
- Consumers who have difficult-to-treat substance abuse disorder of greater than 6 months duration.
- Consumers who are homeless or are unstably housed.
- Consumers who are functioning poorly and do not attend office-based mental health programs on a consistent basis.

AND

(C) The consumer receives services through a DMHA certified Assertive Community Treatment Team.

DEFINITIONS

Arranged Alphabetically

Adjusted Family Income:

Is reported in dollars up to six (6) numbers. The field should express the family unit income as an annualized value. This value is reported AFTER mental health and addiction treatment costs, and/or gambling debt have been deducted. This is a required field, and a value must be reported (you may not report an unknown value). If the consumer is an SED, "family" refers to the family of the person responsible for medical bills. If the state or county is responsible for medical bills, report family income as zero (0).

Age:

Alcohol: age at first intoxication
Other substances: age at first use
'0' indicates newborn with a substance abuse dependency
'99' Unknown

Agency Individual Identifier:

Is coded with agency preferred information that identifies records/individuals within the agency for edit and other data management.

Agreement Identification:

Will be coded as follows along with appropriate designation for Tier Rates:

Seriously Mentally Ill	MI1 - 9
Seriously Emotionally Disturbed	SED
Chronically Addicted	SA1
	CA1 – 4
Chronically Addicted Woman (with Dependent Children or Pregnant)	SW1
	AW1- 4
Co-Occurring Disorder	CM 1 - 4
Deaf (Hard of Hearing) Chronic Addiction / Substance Abuse	DCA
Deaf (Hard of Hearing) Seriously Mentally Ill	DMI
Deaf (Hard of Hearing) Seriously Emotionally Disturbed	DED
Deaf (Hard of Hearing) Gambling	DGM
Compulsive Gambling Addiction	GAM
Methadone Only	SMO
State Operated Facility	SOF
Special Services	SPL
Assertive Community Treatment	ACT

American Indian or Alaskan Native:

American Indian (other than Alaska Native): Origins in any of the original people of North America and South America (including Central America) and who maintain cultural identification through tribal affiliation or community recognition. Alaskan Native (Aleut, Eskimo): Origins in any of the original people of Alaska.

1 Yes
2 No

Asian:
A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand and Vietnam.

1 Yes
2 No

Assertive Community Treatment: (Code ACT):
See page 19.

Assertive Community Treatment (ACT): Is the individual being served by an ACT Team*?

1 Yes
2 No

*In order for the agency to select "Yes" in this field, the agency shall have an ACT contract or have achieved ACT certification or provisional certification with DMHA.

Assessment Date:
Date of assessment data reported on the current Registration/Demographic/Outcome record. For fiscal year 2008 only, Assessments using the HAPI-A that are completed in April, May, or June 2007 and reported on the initial fiscal year 2008 Registration/Demographic/Outcome record, will use the date of the actual HAPI-A results.

Black/African American: Origins in any of the black racial groups of Africa.

1 Yes
2 No

Chronically Addicted (Code: SA or CA):
See page 15.

Clinician Level
This data element identifies the educational level of the individual providing the service described. In those cases where more than one individual provides the service, this element should describe the most senior of the providers. In the case of residential or inpatient services, where the service is provided by a team that changes over time, and may include no face to face contact, the code for "facility" should be used. There will be many cases where the clinician can be coded to more than one category. Use the smallest number. Example: a Psychiatrist (code 01) who is also a Certified Addiction Counselor (code 16) should be coded as a Psychiatrist (code 01).

01 Psychiatrist, Board Eligible or Certified
04 Other MD or DO
07 PhD Psychologist, HSSP or Non-HSSP
10 PhD or Masters in Social Work, Nursing, Counseling, Marriage and Family Therapy, Psychology, LCSW, LMHC or LMFT
13 Other Masters or Other PhD
16 Certified Addiction Counselor
19 RN'S
22 Bachelors
25 Less than Bachelors
28 Facility (Residential Care) Staff

Co-dependent/Collateral:

1 Consumer is a Co-dependent/Collateral and meets the following criteria:
   a. Is seeking services because of problems arising from a relationship with a substance user.
   b. Has been formally admitted for service to a treatment unit.
   c. Has own consumer record or a record within a primary consumer record.
2 Consumer is a primary consumer and should have a 'Substance' listed.

Compulsive Gambling Addiction (Code: GAM):
See page 17.

Co-Occurring Disorder (Coded: CM):
See page 16.

County of Residence:
Is coded using the two-digit code and must be coded 01 through 92 for approval. (Refer to page 37 for County two-digit code listing.)

Criminal Activity:

In the past 30 days, how many times was the individual arrested?

Express as a number (example, “1” indicates the individual was arrested one time in the last 30 days).

Date of Birth:
Enter consumer's date of birth (YYYYMMDD).

Deaf or Hard of Hearing:
Code as:

1 Yes
2 No
9 Unknown

"**Deaf**": Generally describes individual(s) with a profound or significant hearing loss. Mode of communication is generally dependent upon time of hearing loss:

Perlingual - prior to the acquisition of language;
Postlingual - after language acquisition has already begun.

American Sign Language (ASL) is the most common mode of communication, but some individuals prefer to use hearing aids, speech reading and assistive technology to communicate.

"**Hard of Hearing**": Describes individual(s) with a mild to profound hearing loss. Some speech sounds can be understood with or without a hearing aid. Most individuals who are hard of hearing use an oral mode of communication. Some use sign language but the majority is committed to using their residual hearing, hearing aids, speech reading and assistive technology to aid communication. The language and identity of these individuals vary depending upon their background and exposure.

Deaf (Hard of Hearing) (Codes DCA; DMI; DED; DGM):
See page 17-18

Detailed-Not in Labor Force:

RESPOND TO THIS QUESTION ONLY IF "EMPLOYMENT" IS CODED #4.

This field gives more detailed information about consumers who are coded as "Not in the Labor Force." If the consumers respond to the "Employment" field with "Not in Labor Force," then "Detailed Not in Labor Force," must be completed.

01 Homemaker
02 Student
03 Retired
04 Disabled
05 Inmate of institution (prison or institution that keeps a person, otherwise able, from entering the labor force)
06 Other
96 Not Applicable
97 Unknown
98 Not Collected
99 Invalid

NOTE: CSDS will not store values in the Detailed Not In Labor Force field unless Employment is coded "4" Not in Labor Force.

Diagnosis:

Is reported according to DSM-IV. Coding is up to six characters including decimal or "V" followed by characters.

Example: '392.00', '392.0', or '392'.

Primary diagnosis should be the diagnosis which corresponds to the AGREEMENT IDENTIFICATION (field #12) except for GAMBLING where the diagnosis may appear as SECONDARY.

Secondary diagnosis must be used if the individual is enrolled under the agreement type of Co-Occurring Disorders (CM). Secondary diagnosis can be used for Gambling.

Diagnosis code represents the diagnosis associated with the service that is being performed.
Please do not use identical DSM codes for the primary and secondary diagnosis.
See Page 39 for CSDS/HAP acceptable codes for primary diagnoses.

Disability:

Is designed to report only a disability in addition to the disabilities that are directly responsible for the current treatment. The condition of the consumer regarding mental illness and/or substance abuse is reported in greater detail through other fields.

1 None known	2 Blind
3 MR/DD	4 Deaf
5 Mute	6 Non-ambulatory
7 Other Physical/Medical	8 Neurological Impairment
9 Illiterate	10 Other

Education:

0	Not attended school	01-11	Last grade completed
12	High School Graduate	13-15	1 to 3 Years of college
16	College graduate	17	Master's Degree
18	Doctorate Degree	21	Trade or Business School
22	Associate Degree	99	Unknown

Employment:

For **Chronically Addicted/Substance Abuse Consumers** Only:

In the past 30 days, what was the individual's primary employment situation?

For **All Other Consumers**:

At the date of the initial assessment, reassessment, or discharge, what is the individual's employment status?

1 Full-time: working 35 or more hours per week.
2 Part-time: working 20 or fewer hours per week.
3 Unemployed: looking for work during the last 30 days or laid off from a job. *
4 Not In Labor Force: not looking for work during the last 30 days or a homemaker, student, disabled, retired or in an institution.
5 Less than full-time: working 21 to 34 hours per week.
9 Unknown

***Note: If the consumer's "Employment" is reported as "4" – "Not in Labor Force," the "Detailed Not in Labor Force" field MUST BE COMPLETED. Definition and values are found on page 23.**

Encounter Begin Date:

Beginning date of the encounter. This date represents the date when specific services were actually supplied, dispensed, or rendered to the patient.

Encounter services may be reported prior to the date of registration or date of assessment.

Encounter End Date:

Ending date of the encounter. This date represents the date when specific services were completed.

Encounter Units:

List the appropriate units the consumer received for the appropriate service. Encounter Units will vary according to the service and are specified by the specific procedure code (HCPCS or CPT).

Do not use fractional units when reporting. Fractional units will not be stored in CSDS. Example: Consumer received 10 minutes of Case Management (T1016). One unit of T1016 equals 15 minutes. Round minutes up from 10 to 15 minutes which would equal 1 unit of service.

Encounter Value:

An encounter value is the dollar value, or standard charge, for each service rendered to the consumer. The encounter value is determined by the provider, but it must be based on service units. Generally, the rate used will be the same as the provider's usual and customary charge regardless of the provider's expectations for collection.

The Encounter value is to be reported by the provider as the units of service administered to the consumer multiplied by the respective rate for each service. The result is rounded to the nearest whole dollar.

If you have an encounter value, you must provide the encounter unit(s). Do not use zero.

Ethnicity:

Reported as follows and are selected independent of race:

1 Puerto Rican
2 Mexican
3 Cuban
4 Other Hispanic/Latino: Of Central or South America, or any other Spanish culture origin (including Spain).
5 Not Hispanic/Latino: Use this code if the consumer is not of Hispanic Origin. Generally, if race is Alaskan Native, American Indian, or Asian/Pacific Islander, ethnicity would be considered "Not Hispanic". This is not an absolute definition; the decision is made on any available information at the agency level.
6 Latino, Unknown Origin

Family Size:

Is reported as a number of individuals that depend on the "family income" for support. This is a required field, and a value must be reported (you may not report an unknown value). If the consumer is an SED, "family" refers to the family of the person responsible for medical bills. If the state or county is responsible for medical bills, report family size as one (1). (This would be the only time that a minor's family size should be 1.)

Food Stamps Indicator:

Is the consumer receiving food stamps?

1 Yes
2 No

Frequency - of substance intake:

At registration/initial assessment: In the past 30 days, what was the individuals' frequency of use?

At re-assessment or discharge: In the past 30 days or since admission if it was less then 30 days ago, what was the individuals' frequency of use?

1 None in past month
2 One - three times in past month
3 One - two times per week
4 Three - six times per week
5 Daily
8 Not Applicable
9 Unknown

Funding Indicator

Is the Provider requesting funding for consumer in **AGREEMENT TYPES OF ACT, SOF, GAMBLING, METHADONE, DEAF OR SPECIAL SERVICES**? This field can be used either at the time of initial registration or as an update to change a previously unfunded enrollee to funded.

1 Enroll this individual and request funds
2 Enroll this individual, but funds are not requested

Is the consumer being registered as Serious Mental Illness, Chronically Addicted, Chronically Addicted Woman with Dependent Children or Addicted, Co-Occurring Disorders, or Serious Emotional Disturbance?

1 DO NOT USE
2 Use this number for all registrations -- not requesting funding

Gender:

Is reported
M = male
F = female

HAPI-A Level of Function:

Level of function score from the Hoosier Assurance Plan Instrument – Adults form.

Hard of Hearing:

See "Deaf".

Health Insurance:

1 Blue Cross/Blue Shield	2 HMO	3 Other Private Insurance
4 Medicaid	5 Medicare	6 Other
8 None	9 Unknown	

Home and Community Based Service Waiver ("HCBS Waiver")—Community Alternatives to Psychiatric Residential Treatment Facilities [PRTF]

This field will only apply to those consumers who are age 21 and under and who are enrolled in Medicaid. A Medicaid number must be provided as well.

Is the individual being served by the Community Alternatives to PRTF demonstration waiver?

1 Yes
2 No

Illness Management and Recovery ("IMR")

Definition: Includes a broad range of health, lifestyle, and self-assessment and treatment behaviors by the individual with mental illness, often with the assistance and support of others, so they are able to take care of themselves, manage symptoms, and learn ways to cope better with their illness. Self management includes Psychoeducation, behavioral tailoring, early warning sign recognition, coping strategies, social skills training, and cognitive behavioral treatment. If an illness self-management program other than the specific IMR model is being provided to a consumer, then indicate that the service is being provided without fidelity to the model.

Illness Management and Recovery ("IMR") Skills services:

1 Yes, with fidelity to the model (As defined by the SAMHSA Toolkit Project)
2 Yes, without fidelity to the model
3 No

Integrated Dual Diagnosis Treatment ("IDDT")

Definition: Integrated Treatment for Co-occurring Disorders - Dual diagnosis treatments combine or integrate mental health and substance abuse interventions at the level of the clinical encounter. Hence, integrated treatment means that the same clinicians or teams of clinicians, working in one setting, provide appropriate mental health and substance abuse interventions in a coordinated fashion. In other words, the caregivers take responsibility for combining the interventions into one coherent package. For the individual with a dual diagnosis, the services appear seamless, with a consistent approach, philosophy, and set of recommendations. The need to negotiate with separate clinical teams, programs, or systems disappears. The goal of dual diagnosis interventions is recovery from two serious illnesses.

Integrated Dual Diagnosis Treatment ("IDDT"):

1 Yes, with fidelity to the model (As defined by the SAMHSA Toolkit Project)
2 Yes, without fidelity to the model
3 No

Legal Basis/Type of Commitment:

RESPOND TO THIS QUESTION ONLY IF "SOURCE OF REFERRAL" IS CODED #7:

1 State/Federal Court	2 Formal Proceedings
3 Probation/Parole	4 Legal, Other
5 Diversion Program	6 Prison
7 DUI	8 Other
9 Unknown	

Level of Function:

See page 46.

Living Arrangement:

1. Alone or with family, a person is considered homeless if he/she lacks a fixed, regular, and adequate nighttime residence and/or his/her primary nighttime residence is (a) a supervised publicly or privately operated shelter designed to provide temporary living accommodation of 3 or less months, (b) an institution that provides a temporary residence for individuals intended to be institutionalized, or (c) a public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings (e.g., on the street).

2 Residential Facility (24 hours a day, 7 days a week; child or adult), that does or does not provide treatment: supervised living, group home, board & care, crisis residential, rehabilitation center, adult or child residential care/treatment facility, halfway house, therapeutic group home, agency-operated residential care facilities, a supervised publicly or privately operated shelter designed to provide living accommodation for more than 3 months.

3 Independent Living (child or adult): Living with non-foster family without supportive community service being received in the home setting; living in a house, apartment, trailer, hotel, dorm, barrack, single room occupancy, or in the residence of parents, relatives, legal guardians, or other primary caregivers; no routine or planned supportive community service intervention received in order to maintain independence in the living situation. *

4 Living Under Correctional Order or Incarcerated (child or adult): Home detention, detention centers, work release, weekend jail for adults, juvenile home/hall, boys-girls camp/school/ranch, youth authority facility, boot camp, jail, correctional facility, prison

5 Supported Living (child or adult): Living with non-foster family and receives supportive community service in the home setting; living in a house, apartment, trailer, hotel, dorm, barrack, single room occupancy, or in the residence of parents, relatives, legal guardians, or other primary caregivers; receives routine or planned supportive community services and/or financial support for their living arrangement. Includes semi-independent living. There is community support services intervention.

6 Foster Care (child or adult): Individual resides in a foster home. A foster home is a home licensed by a county or State Department to provide foster care to children, adolescents, and/or adults. This includes therapeutic foster care facilities. Therapeutic foster care is a service that provides treatment for troubled children within private homes of trained families.

7 Inpatient (not a state operated facility) hospital or nursing home (child or adult): 24 hour a day, 7 day a week care; skilled nursing/intermediate care facility, nursing home, institutes of mental disease (IMD), inpatient psychiatric hospital, psychiatric health facility, general hospital, private adult or children's psychiatric hospital, Veterans Affairs hospital.

8 Inpatient State Operated Hospital/Institution (child or adult): 24 hour a day, 7 day a week care; state operated facility.
9 Unknown, Unavailable
0 Other

*Supportive community services are individualized services to promote recovery, manage crises, perform activities of daily living and/or manage symptoms, and are not public entitlements. Public entitlements are funding sources that a consumer qualifies for based on income, disability, etc. These include, but are not limited to TANF and food stamps. Consumers can be receiving public entitlements and be considered living independently.

Marital Status:

1 Never Married (includes those whose only marriage was annulled).
2 Married or living together as married.
3 Separated includes those separated legally or otherwise absent from spouse because of marital discord.
4 Divorced (includes marriages legally terminated).
5 Widowed (not remarried after the death of a spouse).
9 Unknown

Medicaid ID:

List consumer's twelve (12) digit Medicaid Identification number.

Medicaid Indicator:

Is consumer enrolled in Medicaid?
1 Yes
2 No

Methadone Only (Coded: SMO):

See page 17.

Native Hawaiian/Other Pacific Islander: A person having origins in any of the original peoples of Hawaii, Guam, Samoa or other Pacific Islands.

1 Yes
2 No

Needle Use:

Has ever used a needle to ingest substance?
1 Shared
2 Yes
3 No
9 Unknown

Number of Consumer's Children Receiving Care:

Enter the number of children receiving childcare. Care must include provision or the arrangement for child care while the mother is in treatment; primary pediatric care, including immunization for the children and therapeutic interventions for the children which may address their developmental needs, sexual and physical abuse and neglect.
0 through 7
8 indicates eight or more

Pregnant:

At the beginning of a clinical episode was consumer pregnant?
1 Yes
2 No

Primary Subcontractor:

Provider/facility/agency code identifying the primary subcontractor performing services for the Provider.

Primary Substance:

List the consumer's first use or main substance preference. In determining primary, secondary and tertiary substance abuse problems, clinical judgment will ultimately determine the degree of impairment that a substance has for an individual consumer. In determining the degree of impairment, the following considerations should be made: (1) pattern of drug involvement; (2) degree of present or past physical, mental, social dysfunction caused by the substance and (3) degree of present or past physical or psychological dependence on drugs, regardless of the frequency of use of a specific drug."

See Substance Code listing on page 38.

Prior SA Treatment Episodes:

Expressed as a number
0 through 4,
5 indicates 5 or more
9 indicates Unknown
Changes in service for the same episode should not be counted as separate prior episodes.

Procedure Code:

DMHA approved service code. The procedure code represents the service the consumer received. See Attachment A.

Provider Number:

This is the three / four digit code assigned to each Provider by FSSA/DMHA (example: 401, 802, 903, 1002, etc.).

Race: See American Indian/Alaskan Native
Asian
Black/African American
Native Hawaiian/Other Pacific Islander
White

Reason Code:

This code represents the “reason” for which the Registration/Demographic/Outcome record is being updated.

Outcome Measures MUST BE reported for each reason code **except** for Reason Code “4” Discharge, “5” Prison, “6” Deceased or ”9” Status Change.

Outcome Measures include updated information on Living Arrangement, Employment, Substance Usage data (primary, secondary and tertiary substances, route of ingestion, frequency of use/intake, and age at first use/intoxication), Roles, ACT, SOC, HCBS Waiver, Criminal Activity, Supported Employment, Integrated Dual Diagnosis Treatment, Illness Management and Recovery, Supported Housing, and Detailed-Not in Labor Force (if

applicable).

0 Registration – Use this code as the reason for submitting the initial Registration/Demographic/Outcome record at the beginning of each episode of care.

A Registration/Demographic/Outcome record is required for each consumer served in fiscal year 2008. If a consumer has been discharged using reason code of 3, 4, or 5 and the consumer re-enters service, a Registration/Demographic/Outcome record is to be completed and Reason Code will be 0 (reactivates the record in CSDS.)

1 180 Days Reassessment: It has been 180 days since the previous assessment.
The provider has recently interviewed the consumer (in person or via telephone) to collect and report to CSDS current outcome measures.
Report any other new information
If consumer is under age 18, report to CSDS and also updated CANS information to the Indiana Behavioral Health Assessment System (IBHAS).

2 Agency Re-assessment: The re-assessment is being performed by the Provider and is in accordance with the agency's normal operating procedures.
The provider has recently interviewed the consumer (in person or via telephone) to collect and report to CSDS current outcome measures.
Report any other new information.
If consumer is under age 18, report to CSDS and also updated CANS information to the Indiana Behavioral Health Assessment System (IBHAS).

3 Mutual Discharge: The Re-assessment is being performed due to a mutual discharge. Current treatment is completed.
Report Outcome Measures
Report any other new information
If consumer is under age 18, report to CSDS and also updated CANS information to the Indiana Behavioral Health Assessment System (IBHAS).

4 Discharge: Termination initiated by the enrollee, enrollee has decided against receiving services, and/or enrollee left against professional advice. Enrollee is not available for re-assessments.
Report Outcome Measures if information is available in the clinical record
If consumer is under age 18, report to CSDS and also updated CANS information to the Indiana Behavioral Health Assessment System (IBHAS).

5 Prison: The enrollee is currently with the Department of Corrections or the Federal Prison System.
Report Outcome Measures if information is available in the clinical record

6 Deceased: The enrollee has died and cannot be re-assessed.
Report Outcome Measures if information is available in the clinical record

7 Special DMHA Request
Report Outcome Measures
Reporting of HAPI A LOF scores are optional

8 Deleted for fiscal year 2008

9 Status Change: It is prior to 180 days since last assessment and one or more fields in the Registration/Demographic/Outcome Record needs to be updated. Report any changes

Registration

Registration is the process of creating a data set within CSDS for a specific consumer. Beginning in SFY 2008, each person receiving services through the Managed Care Providers will be registered into the CSDS system and will be considered an active consumer while receiving services or an inactive consumer if discharged by each provider of services. Once registered in CSDS, the record will be active or inactive and may be reactivated at any time by any provider.

Revenue 3rd Party Other:

Represents the revenue (or payment) received from third party such as the enrollee's health insurance.

Revenue Posting Date:

This is the date the Provider desires this revenue to show as being posted. This requirement was included since revenue (credits and debits) are traced by the quarter it was received. This date is when the revenue is posted into the Provider's account.

Revenue Sources:

Represents the various revenue sources for the enrollee. This value can be negative. Round to the nearest whole dollar. Do not use decimals.

Medicaid (MRO)
Medicaid, Other
Medicare
Non-DMHA Federal: Non-DMHA Title XX, Food Stamps
Non-DMHA State
County/Local
Other: United Way, Cash donations, Fee collection

Roles:

This is a required field for all consumers age 17 and under.

Complete for children and youth (birth to 17) The Restrictiveness of Living Environmental Scale, ROLES (Hawkins, Almeida, Fabry, & Reitz, 1992) measures the restrictiveness of living of children's living situations. Restrictiveness is measured on a scale from 1 (least restrictive) to 16 (most restrictive). Level of restrictiveness is determined by the degree to which individuals are free in the physical facility (use of locks, privacy of bathing), the degree to which rules and requirements infringe on freedom, and voluntariness with which children and youth enter or leave the setting (Cross & McDonald, 1995). ROLES adapted to add "homeless" and "state hospital".[1]

1 **Homeless**: No place to stay; staying anywhere available from night to night
2 **Independent**: Living independently alone or with friend/partner with minimal supervision

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[1] Hawkins, R. P., Almeida, B., Fabry, A. C., & Reitz, A. C. (1992). *A scale to measure restrictiveness of living environments for troubled children and youth*. Hospital and Community Psychiatry, 43, 54-59.

Cross, T. & McDonald, E. (1995). *Evaluating the outcome of children's mental health services: A guide for the use of available child and family outcome measures*. Boston, MA: Judge Baker Children's Center.

3 **Biological Family**: Living with biological caregiver(s)—mother, father, parents
4 **School Dormitory:** Living out of the home in boarding school arrangement (without a treatment component)
5 **Relative's home/adoptive home/ home of a friend**: Living in home of and under care of relative, adoptive parents, or with unrelated family friend with responsible adult in household.
6 **Supervised Independent Living:** Living in supervised community living arrangement without added support or in-house treatment component (i.e., with recruited mentor, professional housemate, or other "paid roommate")
7 **Foster Care**: Living in standard foster care arrangement without added support or in-house treatment component
8 **Therapeutic Foster Care**: Foster care arrangement in which providers are trained to care for children with intense special needs and has an identifiable treatment or support component
9 **Individual home/group Emergency Shelter**: Temporary apartment, specialized foster home or group living arrangement used to provide extensive support and supervision with focus on children with special needs
10 **Group Home:** Alternative living arrangement in which child lives with a small number of other children (e.g., 3 to 9) with special needs. 24-hour supervision is provided along with long-term treatment and supports.
11 **Residential Treatment Center**: Alternative group living arrangement for children with intensive mental health /substance abuse treatment needs with 10 or more children. Provides 24-hour staff supervision. Lengths of stay are generally longer than in hospitals.
12 **Medical Hospital (non-psychiatric**): Living in inpatient unit of medical hospital for treatment of non-mental health-related problems
13 **Psychiatric Hospital**: Acute inpatient unit of a community psychiatric hospital with 24-hour supervision. Intensive mental health treatment component
14 **State Hospital**: Inpatient unit of state psychiatric hospital
15 **Juvenile Detention Center/Youth Correctional Center**: Incarceration of youth in "youth-only" locked facility. May or may not have treatment component
16 **Jail/prison**: Incarceration of youth in locked adult correctional facility with high structure and high supervision

Route - of Substance Ingestion:

1 Oral	2 Smoked
3 Inhaled	4 Injection
8 Other	9 Unknown

Secondary Substance:

List the consumer's second use or secondary drug preference. In determining primary, secondary and tertiary substance abuse problems, clinical judgment will ultimately determine the degree of impairment that a substance has for an individual consumer. In determining the degree of impairment, the following considerations should be made: (1) pattern of drug involvement; (2) degree of present or past physical, mental, social dysfunction caused by the substance and (3) degree of present or past physical or psychological dependence on drugs, regardless of the frequency of use of a specific drug."

See Substance Code listing on page 38.

Seriously Emotionally Disturbed (Coded SED):

See page 16

Seriously Mentally Ill (Coded: MI):

See page 15

SOGS Level of function:

Level of function score from the South Oaks Gambling Screen form. The score reported is to be based on the past twelve (12) months, not the lifetime score.

Source of Referral:

1 Individual/Self: Consumers referred by an individual, including self, family member, friend, or any other individual.

2 Alcohol/Drug Care Provider: Any program, clinic, or any other health care provider whose principal objective is treating consumers with substance, or a program whose activities are related to alcohol or drug abuse prevention, education, or treatment.

3 Health Care, Other: A physician, psychiatrist, or other licensed health care professional; or general hospitals, psychiatric hospitals, mental health programs, or nursing homes.

4 School (Educational): A school principal, counselor, or teacher; or a student assistance program (SAP), the school system, or an educational agency.

5 Employer/Employee Assistance Program: A supervisor or an employee counselor.

6 Other Community Referral: Community and religious organizations or any Federal, State, or local agency that provides aid in the areas of poverty relief, unemployment, shelter or social welfare. Self help groups such as Alcoholics Anonymous (AA), Al-Anon, Narcotics Anonymous (NA), are also included in this category, as well as defense attorneys.

7 Court/Criminal Justice/Driving Under the Influence/Driving While Intoxicated: Any police official, judge, prosecutor, probation officer, or other person affiliated with a Federal, State, or county judicial system and includes:

a. Referrals for DWI/DUI except individual referrals.

b. Referrals in lieu of or for deferred prosecution; or during pretrial release; or before or after adjudication.

c. Pre-parole, pre-release, work or home furlough, or TASC (diversionary programs). Consumer need not be officially designated as 'on parole'.

d. Civil commitment. This category must be further defined in 'Legal Basis/Type of Commitment'.

NOTE: IF SOURCE OF REFERRAL EQUALS ITEM #7, YOU MUST ALSO RESPOND TO "LEGAL BASIS/TYPE OF COMMITMENT".

8 Referral from Child Welfare/Department of Child Services (DCS).

9 Unknown

Sub Provider Code:

This is a three-or-four-digit code for each sub-provider. The code is designated within the agency and is not assigned by DMHA. This field is not the correct field for network sub agencies. **Please use the sub provider field on the new batch screen to indicate you network agency affiliation.**

Substance Abuse (Coded SA or CA):

See page 15 for Chronically Addicted.

Supported Employment

Definition: Mental Health Supported Employment (SE) is an evidence-based service to promote rehabilitation and return to productive employment for persons with serious mental illness. SE programs use a team approach for treatment, with employment specialists responsible for carrying out all vocational services from intake through follow-along. Job placements are: community-based (i.e., not sheltered workshops, not onsite at SE or other treatment agency offices), competitive (i.e., jobs are not exclusively reserved for SE consumers, but open to public), in normalized settings, and utilize multiple employers. The SE team has a small

consumer to staff ratio. SE contacts occur in the home, at the job site, or in the community. The SE team is assertive in engaging and retaining consumers in treatment, especially utilizing face-to-face community visits, rather than phone or mail contacts. The SE team consults/works with family and significant others when appropriate. SE services are frequently coordinated with Vocational Rehabilitation benefits.

Consumer is Receiving Supported Employment ("SE") services (pick one):

1 Supported employment for paid, full-time work (35 hours per week or more with continuing support)
2 Supported employment for paid, less than full-time work (21 to 34 hours per week with continuing support)
3 Supported employment for paid, part-time work (up to 20 hours per week with continuing support)
4 Enrolled in supported employment and not yet employed
5 Not enrolled in or not receiving supported employment services

Supported Housing Services

Definition: Supported Housing consists of services to assist individuals in finding and maintaining appropriate housing arrangements. This activity is premised upon the idea that certain consumers are able to live independently in the community only if they have support from staff for monitoring and/or assisting with daily living responsibilities. The staff assists consumers to select, obtain, and maintain safe, decent, affordable housing and maintain a link to other essential services provided within the community. The objective of supported housing is to help obtain and maintain an independent living situation.

The minimum requirements for reporting supported housing include:

- Staff assigned: Specific staff are assigned to provide supported housing services.
- Housing is integrated: That is, supported housing provides for living situations in settings that are also available to persons who do not have mental illnesses.
- Consumer has the right to tenure: The ownership or lease documents are in the name of the consumer.
- Supported housing is targeted to persons who would not have a viable housing arrangement without this service.
- Affordability: Supported housing assures that housing is affordable (consumers pay no more than 40% of their monthly income on rent and utilities) through adequate rent subsidies, etc.

Supported housing is not reported if the individual lives in a residential treatment program or is being served by the ACT team.

There are currently no fidelity measures for Supported Housing.
Supported Housing Services ("SH"):

1 Yes
2 No

Systems of Care - "SOC"

A System of Care (SOC) is a wide array of mental health and related services and supports organized to work together to provide care. In a SOC, wraparound services are provided through a child and family team.

This field is critical and may be updated throughout the year. This field only applies to those consumers who are children (age 17 and under).

Is the individual being served by a System of Care wrap-around services?

1 Yes
2 No

TANF code:

Is consumer enrolled in the TANF welfare program?

1 Enrolled: The consumer is enrolled in the TANF program.
2 Eligible: The consumer has an adjusted family income of under 250% of the poverty level, and has dependent children living at home, but is not enrolled in the TANF program.
3 Not Eligible: The consumer has an adjusted family income of over 250% of the poverty level or has no dependent children living at home.

Tertiary Substance:

List the consumer's third use or third drug preference. In determining primary, secondary and tertiary substance abuse problems, clinical judgment will ultimately determine the degree of impairment that a substance has for an individual consumer. In determining the degree of impairment, the following considerations should be made: (1) pattern of drug involvement; (2) degree of present or past physical, mental, social dysfunction caused by the substance and (3) degree of present or past physical or psychological dependence on drugs, regardless of the frequency of use of a specific drug."

See Substance Code listing on page 38.

Third (3rd) Party Billing Indicator

Has or will a 3rd Party be billed?

1 Yes
2 No

Transaction:

1 Create record – This code is used for most submissions to provide **new or updated data**.
2 Update existing record – This code is only used **to correct data** that was previously submitted. For example, if a previous submission gave an incorrect race code and the record should be changed, use code 2.

Unique Identifier:

A constructed field that will be used to track consumers across the data system (fffyyyymmddgssss).

fff	First three letters of the first name. If less than three letters, fill with '/' (forward slash).
yyyymmdd	Birth Date (yyyy=year; mm=month; dd=day)
g	Gender
ssss	"Last Four Digits of Consumer's SSN (Social Security Number)":

In the example SSN '123-45-6789' this field would be completed with "6789", this will help further identify consumers.

The agency must provide the last four-digits of the consumer's Social Security Number. If the consumer does not have a social security number, please contact Melissa Shriner at melissa.shriner@fssa.in.gov **Do not use fictitious numbers.**

Veteran:

Is consumer a veteran? This includes any person who has served on "active" duty in the armed forces of the United States, including the Coast Guard. Not counted as veterans are those whose only service was in the Reserves, National Guard or Merchant Marines.

1 Yes
2 No
9 Unknown

White:

Caucasian with origins in any of the people of Europe (including Portugal), North Africa, or the Middle East.

1 Yes
2 No

COUNTY CODES

CODE	COUNTY	CODE	COUNTY	CODE	COUNTY
01	Adams	32	Hendricks	63	Pike
02	Allen	33	Henry	64	Porter
03	Bartholomew	34	Howard	65	Posey
04	Benton	35	Huntington	66	Pulaski
05	Blackford	36	Jackson	67	Putnam
06	Boone	37	Jasper	68	Randolph
07	Brown	38	Jay	69	Ripley
08	Carroll	39	Jefferson	70	Rush
09	Cass	40	Jennings	71	St. Joseph
10	Clark	41	Johnson	72	Scott
11	Clay	42	Knox	73	Shelby
12	Clinton	43	Kosciusko	74	Spencer
13	Crawford	44	LaGrange	75	Starke
14	Daviess	45	Lake	76	Steuben
15	Dearborn	46	LaPorte	77	Sullivan
16	Decatur	47	Lawrence	78	Switzerland
17	DeKalb	48	Madison	79	Tippecanoe
18	Delaware	49	Marion	80	Tipton
19	DuBois	50	Marshall	81	Union
20	Elkhart	51	Martin	82	Vanderburgh
21	Fayette	52	Miami	83	Vermillion
22	Floyd	53	Monroe	84	Vigo
23	Fountain	54	Montgomery	85	Wabash
24	Franklin	55	Morgan	86	Warren
25	Fulton	56	Newton	87	Warrick
26	Gibson	57	Noble	88	Washington
27	Grant	58	Ohio	89	Wayne
28	Greene	59	Orange	90	Wells
29	Hamilton	60	Owen	91	White
30	Hancock	61	Parke	92	Whitley
31	Harrison	62	Perry		

SUBSTANCE USE/ABUSE CODES

CODE	SUBSTANCE
1	**None**
2	**Alcohol**
3	**Cocaine/Crack:** AKA; crack, coke, blow, toot, sow, lady and girl
4	**Marijuana/Hashish:** AKA; Hashish, hash oil, bang, kif, ganja, dope, grass, pot, smoke, hemp, joint, weed, bonde, maryjane, herb, and tea. Includes THC and any other cannabis sativa preparations.
5	**Heroin:** AKA; H, hombre, junk, smack, dope, horse, crap, hand and boy.
6	**Non-Prescription Methadone:** AKA; meth.
7	**Other Opiates & Synthetics:** AKA; drugstore dope, cube, first line, mud, and perks. Includes codeine, Dilaudid, morphine, Demeral, opium and any other drug with morphine-like effects.
8	**PCP:** AKA; angel dust, hog, peace pill, elephant, tranquilizer and dust.
9	**Other Hallucinogens, Ketamine, or GHB/GBL(gamma-hydroxybutyrate, gamma-butyrolactone):** AKA; Special K, electricity, acid, quasey, blotter acid, microdot, white lightning, purple barrels, peyole buttons, mushrooms, shrooms, rooms, rocket fuel, superweed and bad pizza. Includes D, DMT, STP, mescaline and peyote.
10	**Methamphetamine or Methylenedioxymethamphetamine:** AKA; crystal, ice, crank, methedrine, MDMA, Ecstasy.
11	**Other Amphetamines:** Include Benzedrine, Dexedrine, Preludin and Ritalin.
12	**Other Stimulants:** AKA; speed and black beauties.
13	**Benzodiazepine or Flunitrazepam:** Includes Diazepam, Flurazepam, Chlordiazeposice, Clorazepate, Lorazepam, Alprazolam, Oxazepam, Temazepam, Prazepam, Riazolam, Clonazepam, Halazepam, Rivotril, Klonopin, and Rohypnol.
14	**Other Tranquilizers**
15	**Barbiturates:** AKA; Reds and tueys. Includes Phenobarbital, Seconal and Nembutal, etc.
16	**Other Sedatives or Hypnotics:** AKA; yellow jackets, yellows, ludes, 714's and V's. Includes chloral hydrate, Placidyl and Doriden, etc.
17	**Inhalants:** Includes ether, glue, chloroform, nitrous oxide, gasoline, paint thinner, etc.
18	**Over-The-Counter:** Includes aspirin, cough syrup, Sominex, and any other legally obtained, non-prescription medication.
19	**Tobacco and Other Tobacco Products: snuff, pipes, cigars, cigarettes, chew, smokeless tobacco.**
20	**Other**
99	**Unknown** (not allowed for Primary Substance, allowed for Secondary and Tertiary Substances).

ACCEPTABLE PRIMARY DSM-IV CATEGORIES FOR CSDS

The following codes are acceptable as a primary diagnosis code for consumers enrolled in the Hoosier Assurance Plan Community Services Data System.

First Three Digits Of DSM-IV Code	Category	Notes
291	Substance Abuse	
293	Mental Illness	
294	Mental Illness	
295	Mental Illness	
296	Mental Illness	
297	Mental Illness	
298	Mental Illness	
300	Mental Illness	
301	Mental Illness	
302	Mental Illness	Not acceptable for HAP enrollments: 302.7X
303	Substance Abuse	
304	Substance Abuse	
305	Substance Abuse	Not acceptable for HAP enrollments: 305.1, 305.10
306	Mental Illness	
308	Mental Illness	
309	Mental Illness	
310	Mental Illness	
311	Mental Illness	
312	Mental Illness	312.31 Is used under the GAM agreement type
313	Mental Illness	
314	Mental Illness	
316	Mental Illness	
332	Mental Illness	
333	Mental Illness	
347	Mental Illness	
607	Mental Illness	
608	Mental Illness	
625	Mental Illness	
780	Mental Illness	
787	Mental Illness	

RISK LEVEL FLOW CHARTS

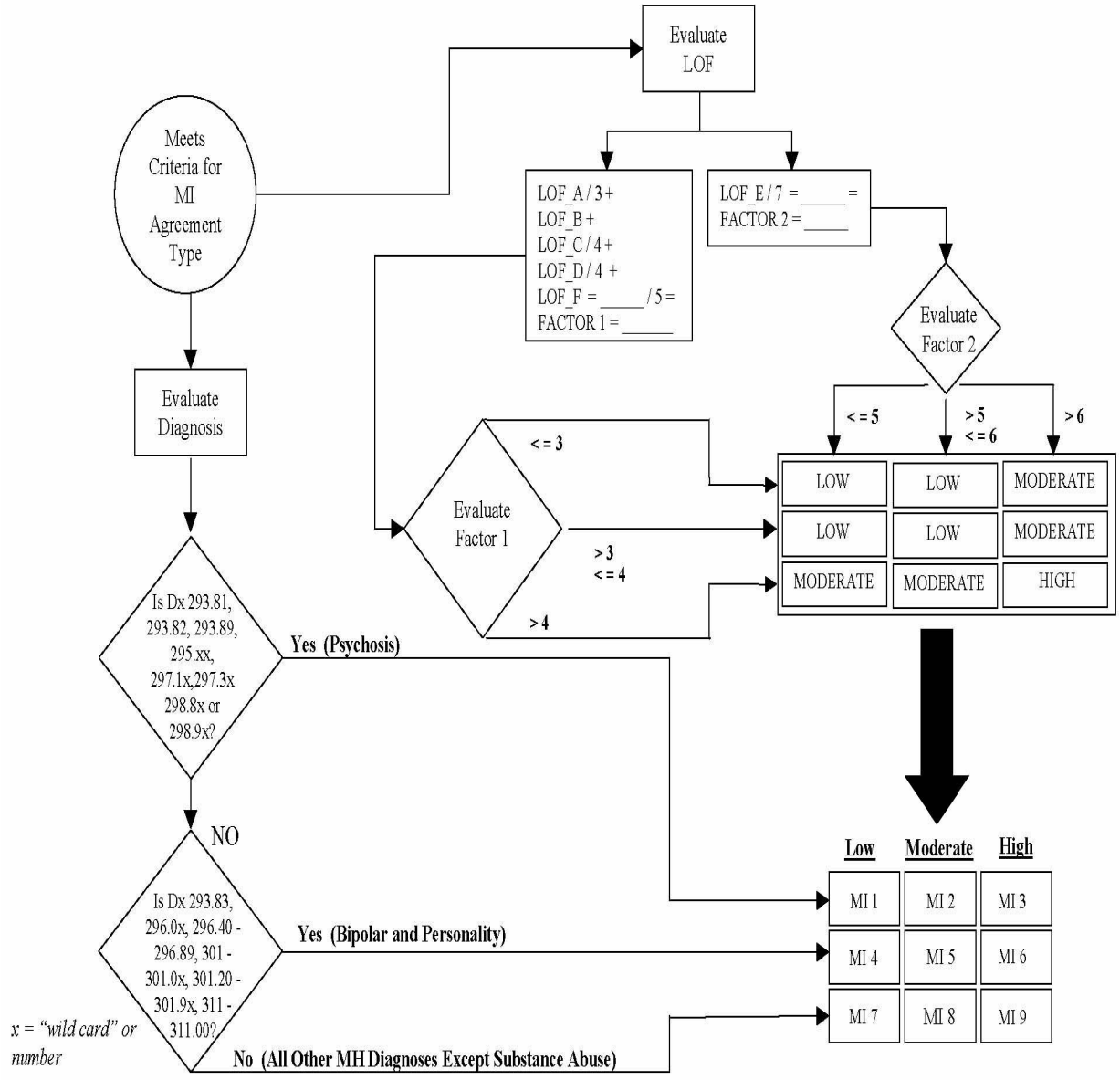
- Mental Illness
- Chronically Addicted
- Co-Occurring Disorders

NOTE: IN ORDER TO AVOID INADVERTENT DIFFERENCES IN THE DETERMINATION OF RISK VALUES, ALL FACTOR SCORES SHOULD BE CALCULATED WITHOUT ROUNDING.

March 18, 2002

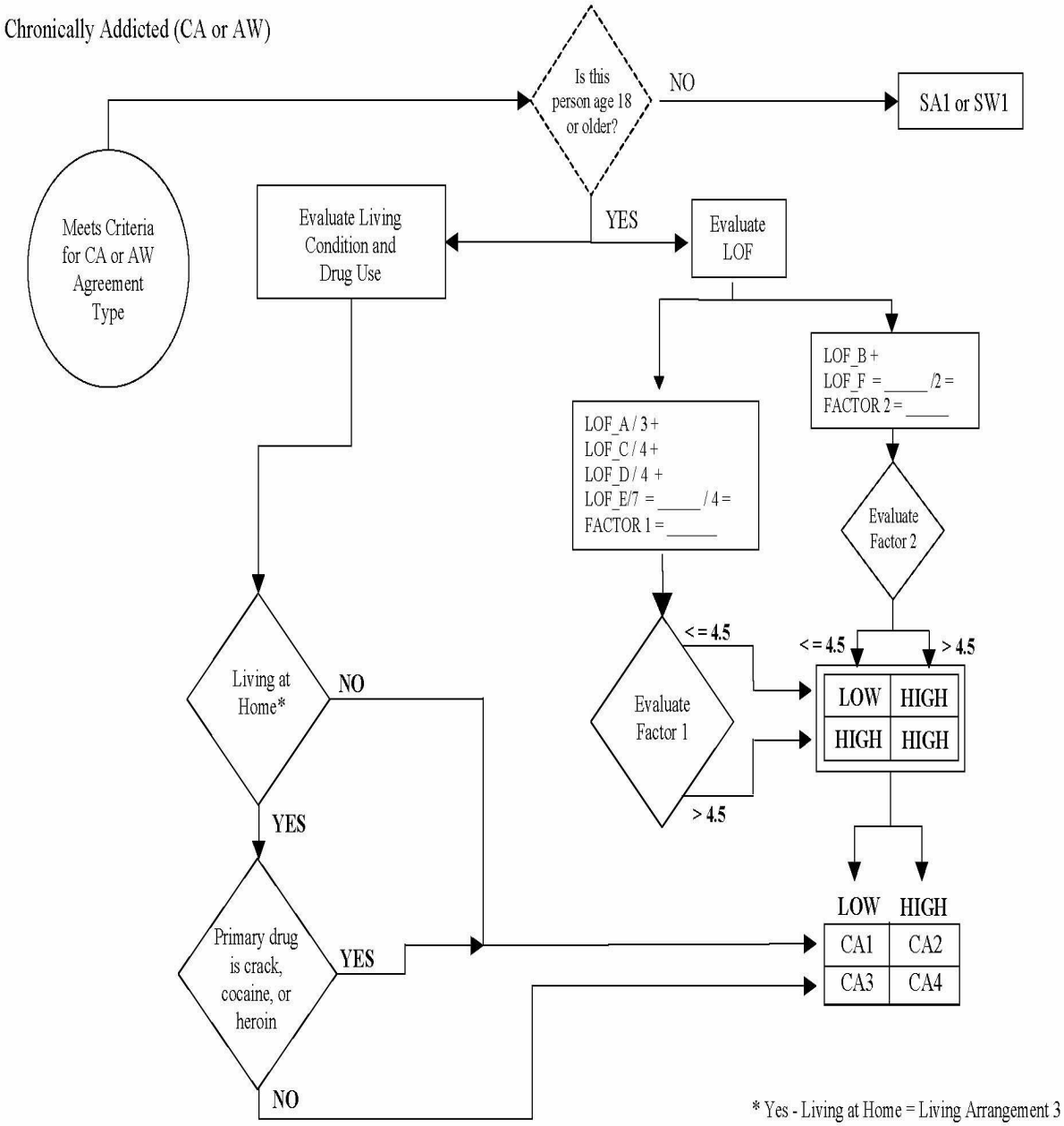
Risk Level Flow Chart

Mental Illness (MI or CM)



April 25, 2002

Risk Level Flow Chart



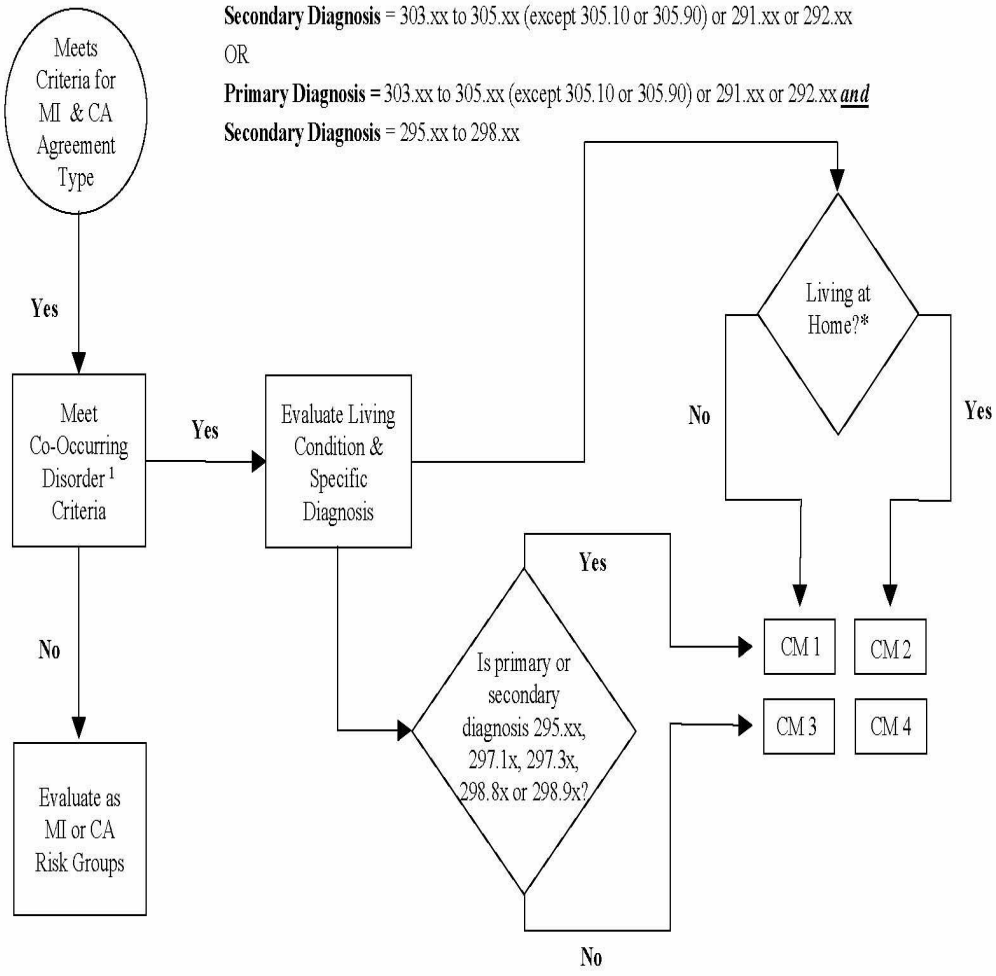
March 7, 2003

Risk Level Flow Chart

Co-Occurring Disorders (CM)

[1] **Individuals must satisfy the following criteria to be considered as having a co-occurring disorder.**

Primary Diagnosis = 295.xx to 298.xx ***and***
Secondary Diagnosis = 303.xx to 305.xx (except 305.10 or 305.90) or 291.xx or 292.xx
OR
Primary Diagnosis = 303.xx to 305.xx (except 305.10 or 305.90) or 291.xx or 292.xx ***and***
Secondary Diagnosis = 295.xx to 298.xx



x = "wild card" or number

* Yes = Living at Home = Living Arrangement 3

SFY 2008 AGREEMENT NAMES; CODES; DESCRIPTIONS; FUNCTIONS; & RATES

Seriously Mentally Ill

Agreement Code	Agreement Description	Agreement Function	Rate	Notes
MI1	Psychosis, age 18+	Low	n/a	
MI2	Psychosis, age 18+	Moderate	n/a	
MI3	Psychosis, age 18+	Moderate	n/a	
MI4	Bipolar, Personality, age 18+	Low	n/a	
MI5	Bipolar, Personality, age 18+	Moderate	n/a	
MI6	Bipolar, Personality, age 18+	High	n/a	
MI7	Other SMI, age 18+	Low	n/a	
MI8	Other SMI, age 18+	Moderate	n/a	
MI9	Other SMI, age 18+	High	n/a	

Co Morbid MI/CA

CM1	Psychosis, not home, age 18+	Low	n/a	
CM2	Psychosis, home, age 18+	Moderate	n/a	
CM3	Other, not home, age 18+	High	n/a	
CM4	Other, home, age 18+	High	n/a	

Chronically Addicted / Substance Abuse

Agreement Code	Agreement Description	Agreement Function	Rate	Notes
Substance Abuse				
SA1	Age < 18		n/a	
CA1	Cocaine/Crack/Heroin, or not home, age 18 +	Low	n/a	
CA2	Cocaine/Crack/Heroin, or not home, age 18+	High	n/a	
CA3	Other drugs, home, age 18+	Low	n/a	
CA4	Other drugs, home, age 18+	High	n/a	

Substance Abuse Women

SW1	Age < 18, female		n/a	
AW1	Cocaine/Crack/Heroin, or not home, age 18+, female	Low	n/a	
AW2	Cocaine/Crack/Heroin, or not home, age 18+, female	High	n/a	
AW3	Other drugs, home, age 18+, female	Low	n/a	
AW4	Other drugs, home, age 18+, female	High	n/a	

Seriously Emotionally Disturbed Children

Agreement Code	Agreement Description	Agreement Function	Rate	Notes
SED	Age < 18		n/a	

Assertive Community Treatment

Agreement Code	Agreement Description	Agreement Function	Rate	Notes
ACT	Assertive Community Treatment		$5,330	**Rate effective date 7/1/06**

State Operated Facility

Agreement Code	Agreement Description	Agreement Function	Rate	Notes
SOF	State Operated Facility **NOTE: SOF1, SOF2, SOF3, SOF4, SOF 7 ARE TO BE CODE AS SOF**		$18,220	

Gambling

Agreement Code	Agreement Description	Agreement Function	Rate	Notes
GAM	Compulsive Gambling		$2,204	

Methadone

Agreement Code	Agreement Description	Agreement Function	Rate	Notes
SMO	Substance Abuse Methadone		$2,250	

Deaf

Agreement Code	Agreement Description	Agreement Function	Rate	Notes
DGM	Deaf – Gambling		$4,500	
DED	Deaf – Seriously Emotionally Disturbed, Age < 18		$4,500	
DMI	Deaf – Seriously Mentally Ill		$4,500	
DCA	Deaf – Substance Abuse		$4,500	

Special Services

Agreement Code	Agreement Description	Agreement Function	Rate	Notes
SPL	Special Services		Provider specific	

LEVEL OF FUNCTION (LOF)

(A) The following LOF reporting is applicable for persons enrolled age 18 and above and only for the initial assessment. Re-assessment LOF data can be left blank.

Hoosier Assurance Plan Instrument – Adults (HAPI-A)				
FIELD # / NAME←□		FACTOR↑	SCALE NAME	SCORE RANGE
17 / 5	LOF (a)	1	Symptoms of Distress & Mood	3 – 21
18 / 6	LOF (b)	2	Physical & Health Status	1 – 7
19 / 7	LOF (c)	3	Community Functioning	4 – 28
20 / 8	LOF (d)	4	Social Support	4 – 28
21 / 9	LOF (e)	5	Risk Behavior & Substance Use	7 – 49
22 / 10	LOF (f)	6	Reliance on Mental Health Services	1 – 7
23 / 11	LOF	-	Not Used	
24 / 12	LOF	-	Not Used	
25 / 13	LOF	-	Not Used	
26 / 14	LOF	-	Not Used	
27 / 15	LOF	-	Not Used	
28 / 16	LOF	-	Not Used	
29 / 17	LOF (n)	5/Item N	Substance Abuse	6 - 42

South Oaks Gambling Screen (SOGS)		
FIELD	SCALE NAME	SCORE RANGE
30	SOGS Level of Function	0 - 20

Note*: To clarify the guidelines for enrollment of problem gamblers please refer to page 18 for more information.*

←□ = Field number represents the field number depending on "Registration/Demographic/Outcome" (fields 17-30).

↑ = Factor refers to "Factor Score Summary" on page 1 of the HAPI-A.

(B) Level of Functioning reporting on the Registration/Demographic/Outcome record is not required for SFY 2008 for consumers aged birth through 17.

ATTACHMENT A

ENCOUNTER/SERVICE CODES

Service Codes
Short Overview of Changes Made from SFY 2007 to SFY 2008

New or Revised Codes Added to CSDS for SFY 2008

CPT Code	Former Definition	New or Revised
95970		Electronic analysis of implanted neurostimulator pulse generator system (e.g., rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); simple or complex brain, spinal cord, or peripheral (nerve, autonomic nerve, neuromuscular) neurostimulator pulse generator/transmitter, without reprogramming
95974		complex cranial nerve neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming with or without nerve interface testing, first hour
95975		complex cranial nerve neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming, each additional 30 minutes after first hour (list separately in addition to code for primary procedure)
H0049		Alcohol and /or drug screening
H0050		Alcohol and /or drug service, brief intervention, per 15 minutes

COMMUNITY SERVICES DATA SYSTEM SERVICE CODING

This portion of the CSDS instruction manual is considered as a "work in progress" and will be updated throughout the year as the Division continues to move toward HIPAA compliance and standardized reporting. If a code is not listed, the Provider should not report that code until DMHA has approved the code for CSDS. The Provider is to make a written request to DMHA to have the new service code added. The request should include the code to be used along with a definition and justification for adding the code. The request should be sent to Melissa Shriner at FSSA / Division of Mental Health and Addiction, W353, 402 West Washington Street, Indianapolis, IN 46204. You may also e-mail the request to melissa.shriner@fssa.in.gov.

Please note the "1 UNIT =" column, the word "session" is used as a "generic term". The word "activity", "event", "interview", "procedure" etc. can be replaced or interchangeable with the word "session".

Reminder: Do not use fractional units when reporting. Fractional units will not be stored in CSDS. Example: Consumer received 10 minutes of Case Management (T1016). One unit of T1016 equals 15 minutes. Round minutes up from 10 to 15 minutes which would equal 1 unit of service.

CPT CODE	*SHORT DESCRIPTION*	*1 UNIT =*	*DEFINITION*
PSYCHIATRY			
90801	Psychiatric Interview	Session	Psychiatric diagnostic interview examination
90802	Interactive psychiatric interview	Session	Interactive psychiatric diagnostic interview examination using play equipment, physical devices, language interpreter, or other mechanisms of communication
NEUROLOGY AND NEUROMUSCULAR			
95970	Subsequent electronic analysis of previously-implanted simple or complex brain, spinal cord, or peripheral neurostimulator pulse generator system without reprogramming.	Session	Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); simple or complex brain, spinal cord, or peripheral (ie, cranial nerve, peripheral nerve, autonomic nerve, neuromuscular) neurostimulator pulse generator/transmitter, without reprogramming.
95974	Intraoperative (at initial insertion/revision) or subsequent electronic analysis of an implanted complex cranial nerve programming.	60 minutes	Complex cranial nerve neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming, with or without nerve interface testing, first hour
95975	Intraoperative (at initial insertion/revision) or subsequent electronic analysis of an implanted complex cranial nerve programming.	30 minutes	Complex cranial nerve neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming, each additional 30 minutes after first hour (List separately in addition to code for primary procedure)
PSYCHIATRIC THERAPEUTIC PROCEDURES			
Office or Other Outpatient Facility ***Insight Oriented, Behavior Modifying and/or Supportive Psychotherapy***			
90804	Individual 20-30 minutes	20 – 30 Minutes	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 20 to 30 minutes face-to-face with the patient;
90805	With medical evaluation	20 – 30 Minutes	With medical evaluation and management services
90806	Individual 45-50 minutes	45 – 50 Minutes	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 45-50 minutes face-to-face with the patient;
90807	With medical evaluation	45 – 50 Minutes	With medical evaluation and management services
90808	Individual 75-80 minutes	75 – 80 Minutes	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 75-80 minutes face-to-face with the patient;
90809	With medical evaluation	75 – 80 Minutes	With medical evaluation and management services
S9480	Intensive Outpatient Psychiatric Services	Session	Intensive outpatient psychiatric services, per diem.
INTERACTIVE PSYCHOTHERAPY			
90810	Individual interactive 20-30 minutes	20 – 30 Minutes	Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non verbal communication, in an office or outpatient facility, approximately 20-30 minutes face-to-face with the patient;
90811	With medical evaluation	20 – 30 Minutes	With medical evaluation and management services
90812	Individual interactive 45-50 minutes	45 – 50 Minutes	Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non verbal communication, in an office or outpatient facility, approximately 45-50 minutes face-to-face with the patient;
90813	With medical evaluation	45 – 50 Minutes	With medical evaluation and management services
90814	Individual interactive 75-80 minutes	75 – 80 Minutes	Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non verbal communication, in an office or outpatient facility, approximately 75-80 minutes face-to-face with the patient;
90815	With medical evaluation	75 – 80 Minutes	With medical evaluation and management services

INPATIENT HOSPITALIZATION, PARTIAL HOSPITALIZATION OR RESIDENTIAL CARE FACILITY			
90816	Individual insight oriented 20-30 minutes	20 – 30 Minutes	Individual psychotherapy, insight oriented behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 20-30 minutes face-to-face with the patient;
90817	With medical evaluation	20 – 30 Minutes	With medical evaluation and management services
90818	Individual insight oriented 45-50 minutes	45 – 50 Minutes	Individual psychotherapy, insight oriented behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 45-50 minutes face-to-face with the patient;
90819	With medical evaluation	45 – 50 Minutes	With medical evaluation and management services
90821	Individual insight oriented 75-80 minutes	75 – 80 Minutes	Individual psychotherapy, insight oriented behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 75-80 minutes face-to-face with the patient;
90822	With medical evaluation	75 – 80 Minutes	With medical evaluation and management services
INTERACTIVE PSYCHOTHERAPY			
90823	Individual interactive in patient, partial hospital or residential 20-30 minutes	20 – 30 Minutes	Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of nonverbal communication, in an inpatient hospital or residential care setting, approximately 20-30 minutes face-to-face with the patient;
90824	With medical evaluation	20 – 30 Minutes	With medical evaluation and management services
90826	Individual interactive in patient hospital or residential 45-50 minutes	45 – 50 Minutes	Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of nonverbal communication, in an inpatient hospital or residential care setting, approximately 45-50 minutes face-to-face with the patient;
90827	With medical evaluation	45 – 50 Minutes	With medical evaluation and management services
90828	Individual interactive in patient hospital or residential 75-80 minutes	75 – 80 Minutes	Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of nonverbal communication, in an inpatient hospital or residential care setting, approximately 75-80 minutes face-to-face with the patient;
90829	With medical evaluation	75 – 80 Minutes	With medical evaluation and management services
OTHER PSYCHOTHERAPY			
90845	Psychoanalysis	Session	Psychoanalysis
90846	Family without patient	Session	Family psychotherapy (without the patient present)
90847	Family conjoint with patient	Session	Family Psychotherapy (conjoint psychotherapy) (with patient present)
90849	Multiple family group	Session	Multiple-family group psychotherapy
90853	Group not multiple family	Session	Group psychotherapy (other than of a multiple-family group)
90857	Interactive group	Session	Interactive group psychotherapy
OTHER PSYCHIATRIC SERVICES OR PROCEDURES			
90862	Medication review with minimal psychotherapy	Session	Pharmacological management, including prescription, use, and review of medication with no more than minimal medical psychotherapy
90865	Narcosynthesis	Session	Narcosynthesis for psychiatric diagnostic and therapeutic purposes (e.g., sodium amobarbital (Amytal) interview)
90870	Electroconvulsive single seizure	Session	Electroconvulsive therapy (includes necessary monitoring); single seizure
90875	Individual with biofeedback 20-30 minutes	20 – 30 Minutes	Individual psychophysiological therapy incorporating biofeedback training by any modality (face-to-face with the patient), with psychotherapy (e.g., insight oriented, behavior modifying or supportive psychotherapy); approximately 20-30 minutes
90876	45-50 minutes	45 – 50 Minutes	Approximately 45-50 minutes
90880	Hypnotherapy	Session	Hypnotherapy
90882	Intervention with agencies etc.	Session	Environmental intervention for medical management purposes on a psychiatric patients behalf with agencies, employers, or institutions
90885	Review of reports and tests for diagnostic purposes	Session	Psychiatric evaluation of hospital records, other psychiatric reports, psychometric and/or projective tests, and other accumulated data for medical diagnostic purposes
90887	Interpretation of reports to families	Session	Interpretation or explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible person, or advising them how to assist patient.
90889	Preparation of reports for physicians etc.	Session	Preparation of report of patients psychiatric status, history, treatment, or progress (other than for legal or consultative purposes) for other physicians, agencies, or insurance carriers
90899	Unlisted psychiatric service	Session	Unlisted psychiatric service or procedure
BIOFEEDBACK (for psychophysiological therapy incorporating biofeedback training, see 90875, 90876)			
90901	Biofeedback	Session	Biofeedback training by any modality
90911	Biofeedback perineal, anorectal or urethral	Session	Biofeedback training, perineal muscles, anorectal or urethral sphincter, including EMG and/or manometry
CASE MANAGEMENT SERVICES			
TEAM CONFERENCE			
99361	Medical conference, interdisciplinary team without patient 30 minutes	30 Minutes	Medical Conference by a physician with interdisciplinary team of health professionals or representatives of community agencies to coordinate activities of patient care (patient not present) approximately 30 minutes

99362	60 minutes	60 Minutes	Approximately 60 minutes
S0220	Medical Conference, interdisciplinary team with patient 30 minutes	30 Minutes	Medical Conference by a physician with interdisciplinary team of health professionals or representatives of community agencies to coordinate activities of patient care (patient is present) approximately 30 minutes
S0221	Medical Conference, interdisciplinary team with patient 60 minutes	60 Minutes	Medical Conference by a physician with interdisciplinary team of health professionals or representatives of community agencies to coordinate activities of patient care (patient is present) approximately 60 minutes
TELEPHONE CALLS			
99371	Telephone call by physician for coordination of care	Session	Telephone call by a physician to patient or for consultation or medical management or for coordinating medical management with other health care professionals (e.g.; nurses, therapists, social workers, nutritionists, physicians, pharmacists); simple or brief (e.g., report on tests and/or laboratory results, to clarify or alter previous instructions, to integrate new information from other health professionals into the medical treatment plan, or to adjust therapy)
99372	Telephone call intermediate	Session	Telephone call intermediate (e.g., to provide advice to an established patient on a new problem, to initiate therapy that can be handled by telephone, to discuss test results in detail, to coordinate medical management of a new problem in an established patient, to discuss and evaluate new information and details, or to initiate new plan of care)
99373	Telephone call complex or lengthy	Session	Telephone call complex or lengthy (e.g., lengthy counseling session with anxious or distraught patient, detailed or prolonged discussion with family members regarding seriously ill patient, lengthy communications necessary to coordinate complex services of several different health professionals working on different aspects of the total patient care plan)

PREVENTIVE MEDICINE SERVICES			
ESTABLISHED PATIENT			
99391	Preventive medicine re-evaluation (age under 1 year)	Session	Periodic comprehensive preventive medicine reevaluations and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of appropriate immunizations(s), laboratory/diagnostic procedures, new patient; infant (age under 1 year).
99392	Age 1-4	Session	Early childhood (age 1 through 4)
99393	Age 5-11	Session	Late Childhood (age 5 through 11 years)
99394	Age 12-17	Session	Adolescent (age 12 through 17 years)
99395	Age 18-39	Session	18-39 years
99396	Age 40-64	Session	40-64 years
99397	Over 65 years	Session	65 years and over
PREVENTIVE MEDICINE SERVICES			
INDIVIDUAL COUNSELING			
99401	Preventive Medicine Counseling	15 Minutes	Preventive Medicine Counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 15 minutes
99402	Preventive Medicine Counseling	30 Minutes	Preventive Medicine Counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 30 minutes
99403	Preventive Medicine Counseling	45 Minutes	Preventive Medicine Counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 45 minutes
99404	Preventive Medicine Counseling	60 Minutes	Preventive Medicine Counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 60 minutes
PREVENTIVE MEDICINE SERVICES			
GROUP COUNSELING			
99411	Preventive Medicine Group Counseling	30 Minutes	Preventive Medicine Counseling and/or risk factor reduction intervention(s) provided to individuals in a group setting (separate procedure); approximately 30 minutes.
99412	Preventive Medicine Group Counseling	60 Minutes	Preventive Medicine Counseling and/or risk factor reduction intervention(s) provided to individuals in a group setting (separate procedure); approximately 60 minutes.
PREVENTIVE MEDICINE SERVICES			
OTHER			
99420	Administration and Interpretation	Session	Administration and interpretation of health risk assessment instrument (e.g., health hazard appraisal).
99429	Unlisted Procedure	Session	Unlisted preventive medicine service
EVALUATION & MANAGEMENT – OFFICE OR OTHER OUTPATIENT SERVICES – SERVICES PROVIDED BY A PHYSICIAN			
NEW PATIENT			
99201	Level 1	Per Visit	Office or other outpatient visit for the evaluation and management of a new patient which requires these three key components: A problem focused history; A problem focused examination; Straightforward medical decision-making. Usually the presenting problems are self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient or family
99202	Level 2	Per Visit	Office or other outpatient visit for the evaluation and management of a new patient which requires these three key components: An expanded problem focused history; An expanded problem focused examination; Straightforward medical decision-making. Usually the presenting problems are of low to moderate severity. Physicians typically spend 20 minutes face-to-face with the patient or family

99203	Level 3	Per Visit	Office or other outpatient visit for the evaluation and management of a new patient which requires these three key components: A detailed history; A detailed examination and Medical decision making of low complexity. Usually the presenting problems are of moderate severity. Physicians typically spend 30 minutes face-to-face with the patient or family.
99204	Level 4	Per Visit	Office or other outpatient visit for the evaluation and management of a new patient which requires these three key components: A comprehensive history; A comprehensive examination and Medical decision making of moderate complexity. Usually the presenting problems are of moderate to high severity. Physicians typically spend 45 minutes face-to-face with the patient or family.
99205	Level 5	Per Visit	Office or other outpatient visit for the evaluation and management of a new patient which requires these three key components: A comprehensive history; A comprehensive examination and Medical decision making of high complexity. Usually the presenting problems are of moderate to high severity. Physicians typically spend 60 minutes face-to-face with the patient or family.
EVALUATION & MANAGEMENT – OFFICE OR OTHER OUTPATIENT SERVICES – SERVICES PROVIDED BY A PHYSICIAN			
ESTABLISHED PATIENT			
99211	Level 1	Per Visit	Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician. Usually, the presenting problem(s) are minimal. Typically 5 minutes are spent performing or supervising these services.
99212	Level 2	Per Visit	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: A problem focused history; A problem focused examination; Straightforward medical decision-making. Usually the presenting problems are self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family
99213	Level 3	Per Visit	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: An expanded problem focused history; An expanded problem focused examination; Medical decision making of low complexity Usually the presenting problems are of low to moderate severity. Physicians typically spend 15 minutes face-to-face with the patient and/or family.
99214	Level 4	Per Visit	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: An detailed history; An detailed examination; Medical decision making of moderate complexity Usually the problems are of moderate to high severity. Physicians typically spend 25 minutes face-to-face with the patient and/or family.
99215	Level 5	Per Visit	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: An comprehensive history; An comprehensive examination; Medical decision making of high complexity Usually, the presenting problems are of moderate to high severity. Physicians typically spend 40 minutes face-to-face with the patient and/or family.
OBSERVATION CARE			
99217	Observation Care Discharge	Per Visit	Observation care discharge day management including Admission and Discharge Services, 99234-99236 as appropriate. (This code is to be utilized by the physician to report all services provided to a patient on discharge from "observation status" if the discharge is on other than the initial date of "observation status". To report services to a patient designated as "observation status" or "inpatient status" and discharged on the same date, use the codes for observation or inpatient care services.
99218	Initial Observation Care	Per Visit	Initial observation care, per day, for the evaluation and management of a patient which requires these three key components: a detailed or comprehensive history; a detailed or comprehensive examination and medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family needs. Usually, the problem(s) requiring admission to "observation status" are of low severity.
99219	Initial Observation Care	Per Visit	Initial observation care, per day, for the evaluation and management of a patient which requires these three key components: a comprehensive history; a comprehensive examination and medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family needs. Usually, the problem(s) requiring admission to "observation status" are of moderate severity.

99220	Initial Observation Care	Per Visit	Initial observation care, per day, for the evaluation and management of a patient which requires these three key components: a comprehensive history; a comprehensive examination and medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family needs. Usually, the problem(s) requiring admission to "observation status" are of high severity.
PROLONGED PHYSICIAN SERVICES			
99354	Prolonged Physician Service	60 Minutes	Prolonged physician service in the office or other outpatient setting requiring direct (face-to-face) patient contact beyond the usual service (e.g., prolonged care and treatment of an acute asthmatic patient in an outpatient setting) first hour (List separately in addition to code for office or other outpatient Evaluation and Management Services).
99355	Prolonged Physician Service	Each Additional 30 Minutes	Prolonged physician service in the office or other outpatient setting requiring direct (face-to-face) patient contact beyond the usual service. Each additional 30 minutes. (List separately in addition to code for prolonged physician service).
99356	Prolonged Physician Services in an In-patient setting	60 Minutes	Prolonged physician service in the inpatient setting requiring direct (face-to-face) patient contact beyond the usual service (e.g., maternal fetal monitoring for high risk delivery or other physiological monitoring, prolonged care of an acutely ill inpatient); first hour. (List separately in addition to code for inpatient Evaluation and Management service).
99357	Prolonged Physician Services in an In-patient setting	Each Additional 30 Minutes	Prolonged physician service in the inpatient setting requiring direct (face-to-face) patient contact beyond the usual service. Each additional 30 minutes. (List separately in addition to code for prolonged physician service).
99358	Prolonged Evaluation and Management Service before and/or After Direct (face-to-face) patient care	60 Minutes	Prolonged evaluation and management service before and/or after direct (face-to-face) patient care (e.g., review of extensive records and tests, communication with other professionals and/or the patient /family). First hour. (List separately in addition to code(s) for other physician service(s) and/or inpatient or outpatient Evaluation and Management service).
99359	Prolonged Evaluation and Management Service before and/or After Direct (face-to-face) patient care	Each Additional 30 Minutes	Prolonged evaluation and management service before and/or after direct (face-to-face) patient care (e.g., review of extensive records and tests, communication with other professionals and/or the patient/family). Each additional 30 minutes. (List separately in addition to code for prolonged physician service).
WORK RELATED OR MEDICAL DISABILITY EVALUATION SERVICES			
99455	Disability examination	Session	Work Related or medical disability examination by the treating physician that includes: Completion of a medical history commensurate with the patient's condition performance of an examination commensurate with the patient's condition Formulation of a diagnosis, assessment of capabilities and stability, and calculation of impairment Development of future medical treatment plan Completion of necessary documentation/certificates and report.
99456	Other than treating physician	Session	Work related or medical disability examination by other than the treating physician

CONSULTATION			
OFFICE OR OTHER OUTPATIENT CONSULTATIONS USED TO REPORT CONSULTATIONS PROVIDED IN A PHYSICIAN'S OFFICE OR IN AN OUTPATIENT OR OTHER AMBULATORY FACILITY, INCLUDING HOSPITAL OBSERVATION SERVICES HOME SERVICES, DOMICILIARY, REST HOME, CUSTODIAL CARE OR EMERGENCY DEPARTMENT			
99241	Level 1	Per Visit	Office Consultation for a new or established patient, which requires these three key components A problem focused history A problem focused examination Straightforward medical decision making Usually the problems are self limited or minor. Physicians typically spend 15 minutes face-to-face with the patient and/or family.
99242	Level 2	Per Visit	Office Consultation for a new or established patient, which requires these three key components An expanded problem focused history A expanded problem focused examination Straightforward medical decision making Usually the problems are of low severity. Physicians typically spend 30 minutes face-to-face with the patient and/or family.
99243	Level 3	Per Visit	Office Consultation for a new or established patient, which requires these three key components A detailed history A detailed examination Medical decision making of low complexity Usually the problems are of moderate severity. Physicians typically spend 40 minutes face-to-face with the patient and/or family.
99244	Level 4	Per Visit	Office Consultation for a new or established patient, which requires these three key components A comprehensive history A comprehensive examination Medical decision making of moderate complexity Usually the problems are of moderate to high severity. Physicians typically spend 60 minutes face-to-face with the patient and/or family.

99245	Level 5	Per Visit	Office Consultation for a new or established patient, which requires these three key components An comprehensive history A comprehensive examination Medical decision making of high complexity Usually the problems are of moderate to high severity. Physicians typically spend 80 minutes face-to-face with the patient and/or family.
CARE PLAN OVERSIGHT			
99374	Physician Supervision Home Health Agency 15-29 Minutes	15-29 Minutes	Physician supervision of a patient under care of home health agency (patient not present) in home, domiciliary or equivalent environment (e.g., Alzheimer's facility) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (e.g., legal guardian) and/or key caregiver(s) involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 15-29 minutes.
99375	Physician Supervision Home Health Agency 30 Minutes or More	More than 30 Minutes	Physician supervision of a patient under care of home health agency (patient not present) in home, domiciliary or equivalent environment (e.g., Alzheimer's facility) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (e.g., legal guardian) and/or key caregiver(s) involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 30 minutes or more.
99377	Physician Supervision Hospice Patient 15-29 Minutes	15-29 Minutes	Physician supervision of a hospice patient (patient not present) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (e.g., legal guardian) and/or key caregiver(s) involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 15-29 minutes.
99378	Physician Supervision Hospice Patient 30 Minutes or More	More than 30 Minutes	Physician supervision of a hospice patient (patient not present) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (e.g., legal guardian) and/or key caregiver(s) involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 30 minutes or more.
99379	Physician Supervision Nursing Facility 15-29 Minutes	15-29 Minutes	Physician supervision of a nursing facility patient (patient not present) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (e.g., legal guardian) and/or key caregiver(s) involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 15-29 minutes.
99380	Physician Supervision Nursing Facility 30 Minutes or More	More than 30 Minutes	Physician supervision of a nursing facility patient (patient not present) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (e.g., legal guardian) and/or key caregiver(s) involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 30 minutes or more.
CENTRAL NERVOUS SYSTEM ASSESSMENTS / TESTS (e.g. Neruo – Cognitive, Mental Status, Speech Testing)			
96101	Psychological Testing	Per Hour	**Psychological testing (includes psycho diagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, eg MMPI, Rorshach, WAIS) per hour of the psychologist's or physician's time, both face-to-face time with patient and time interpreting test results and preparing the report.**
96102	Psychological Testing	Per Hour	**Psychological testing (includes psycho diagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, eg, MMPI and WAIS) with qualified health care professional interpretation and report, administered by a technician, per hour of technician time, face-to-face.**
96103	Psychological Testing	Per Hour	**Psychological testing (includes psycho diagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, eg. MMPI) administered by a computer, with qualified health care professional interpretation and report.**

96105	Boston Diagnostic Aphasia Exam	Per Hour	Assessment of aphasia (includes assessment of expressive and receptive speech and language function, language comprehension, speech production, ability, reading, spelling, writing, e.g., by Boston Diagnostic Aphasia Examination) with interpretation and report, per hour
96110	Developmental screening Test II, Early Milestone Screen	Session	Developmental testing; limited (e.g., Developmental Screening Test II, Early Language Milestone Screen), with interpretation and report
96111	Bayley Scales of Infant Development	Per Hour	Developmental testing; extended (e.g., includes assessment of motor, language, social, adaptive and/or cognitive functioning by standardized developmental instruments, e.g., Bayley Scales of Infant Development) with interpretation and report, per hour
96116	Neurobehavioral status exam	Per Hour	**Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, eg, acquired knowledge, attention, language, memory, planning and problem solving and visual spatial abilities.) per hour of the psychologist's or physician's time, both face-to-face time with the patient and time interpreting test results and preparing the report.**
96118	**Neuropsychological Testing by Psychologist or Physician's**	Per Hour	**Neuropsychological testing (eg, Halstead-Reitan Neuropsychological Battery, Wechsler Memoriy Scales and Wisconsin Card Sorting Test,) Per hour of the psychologist or physician's time, both face-to-face time with the patient and time interpreting test results and preparing the report.**
96119	**Neuropsychological Testing by Technician**	Per Hour	**Neuropsychological testing (eg, Halstead-Reitan Neuropsychological Battery, Wechsler Memory Scales and Wisconsin Card Sorting Test,) with qualified health care professional interpretation and report, administered by a technician, per hour of technician time, face-to-face.**
96120	**Neuropsychological Testing by Computer**	Per Visit	**Neuropsychological testing (eg, Wisconsin Card Sorting Test), administered by a computer, with qualified health care professional interpretation and report.**
HEALTH AND BEHAVIOR ASSESSMENT/INTERVENTION			
96150	Initial Health and Behavior Assessment	15 Minutes	Health and behavior assessment (e.g., health-focused clinical interview, behavioral observations, psychophysiological monitoring, health-oriented questionnaires), each 15 minutes face-to-face with the patient; initial assessment.
96151	Initial Health and Behavior Re-Assessment	15 Minutes	Health and behavior assessment (e.g., health-focused clinical interview behavioral observations, psychophysiological monitoring, health-oriented questionnaires), each 15 minutes face-to-face with the patient; initial re-assessment.
96152	Health and Behavior Intervention Individual	15 Minutes	Health and behavior intervention, each 15 minutes, face-to-face; individual
96153	Health and Behavior Intervention Group	15 Minutes	Health and behavior intervention, each 15 minutes, face-to-face; group (2 or more patients).
96154	Health and Behavior Intervention Family with Patient	15 Minutes	Health and behavior intervention, each 15 minutes, face-to-face; family (with the patient present).
96155	Health and Behavior Intervention Family without Patient	15 Minutes	Health and behavior intervention, each 15 minutes, face-to-face; family (without the patient present).
HOSPITAL INPATIENT SERVICES ***Codes used to report evaluation and management services provided to hospital inpatients. Hospital inpatient services include those services provided to patients in a "partial hospital" setting. These codes are to be used to report those partial hospitalization services. See also psychiatry notes in the full text of CPT.***			
INITIAL HOSPITAL CARE			
NEW OR ESTABLISHED			
99221	Level 1	Per Visit	Initial hospital care, per day for the evaluation and management of a patient which requires these three components: A detailed or comprehensive history A detailed or comprehensive examination Medical decision making that is straightforward or of low complexity. Usually the problems requiring admission are of low severity. Physicians typically spend 30 minutes at the bedside and on the patient's hospital floor or unit.
99222	Level 2	Per Visit	Initial hospital care, per day for the evaluation and management of a patient which requires these three components: A comprehensive history A comprehensive examination Medical decision making of moderate complexity. Usually the problems requiring admission are of moderate severity. Physicians typically spend 50 minutes at the bedside and on the patient's hospital floor or unit.
99223	Level 3	Per Visit	Initial hospital care, per day for the evaluation and management of a patient which requires these three components: A comprehensive history A comprehensive examination Medical decision making of high complexity. Usually the problems requiring admission are of high severity. Physicians typically spend 70 minutes at the bedside and on the patient's hospital floor or unit.
SUBSEQUENT HOSPITAL CARE ***All levels of subsequent hospital care include reviewing the medical record and reviewing the results of diagnostic studies and changes in the patient's status (i.e., changes in history, physical condition and response to management) since the last assessment by the physician.***			
99231	Level 1	Per Visit	Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least two of these three key components: A problem focused interval history A problem focused examination Medical decision making that is straightforward or of low complexity Usually, the patient is stable, recovering or improving. Physicians typically spend 15 minutes at the bedside and on the patient's hospital floor or unit.

99232	Level 2	Per Visit	Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least two of these three key components: An expanded problem focused interval history An expanded problem focused examination Medical decision making that is straightforward or of moderate complexity Usually, the patient is responding inadequately to therapy or has developed a minor complication. Physicians typically spend 25 minutes at the bedside and on the patient's hospital floor or unit.
99233	Level 3	Per Visit	Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least two of these three key components: A detailed interval history A detailed examination Medical decision making of high complexity Usually, the patient is unstable or has developed a significant complication. Physicians typically spend 35 minutes at the bedside and on the patient's hospital floor or unit.

OBSERVATION OR INPATIENT CARE SERVICES (including Admission & Discharge Services) ***Codes are used to report observation or inpatient hospital care services provided to patients admitted and discharged on the same date of service***			
99234	Level 1	Session	Observation or inpatient hospital care, for the evaluation and management of a patient including admission and discharge on the same date which requires these three key components: A detailed or comprehensive history A detailed or comprehensive examination Medical decision making that is straightforward or of low complexity Usually the presenting problems requiring admission are of low severity.
99235	Level 2	Session	Observation or inpatient hospital care, for the evaluation and management of a patient including admission and discharge on the same date which requires these three key components: A comprehensive history A comprehensive examination Medical decision making of moderate complexity Usually the presenting problems requiring admission are of moderate severity.
99236	Level 3	Session	Observation or inpatient hospital care, for the evaluation and management of a patient including admission and discharge on the same date which requires these three key components: A comprehensive history A comprehensive examination Medical decision making of high complexity Usually the presenting problems requiring admission are of high severity.
HOSPITAL DISCHARGE SERVICES ***The hospital discharge day management codes are to be used to report the total duration of time spent by a physician for final hospital discharge of a patient. The codes include, as appropriate, final examination of the patient, discussion of the hospital stay, even of the time spent by the physician on that date is not continuous, instructions for continuing care to all relevant caregivers, and preparation of discharge records, prescriptions and referral forms.***			
99238	Discharge Day up to 30 minutes	Up to 30 Minutes	Hospital discharge day management; 30 minutes or less
99239	Over 30 minutes	More Than 30 Minutes	More than 30 minutes
HOSPITAL INPATIENT CONSULTATIONS ***NEW OR ESTABLISHED*** ***Used to report physician consultations provided to hospital inpatients, residents of nursing facilities or patients in a partial hospital setting.***			
99251	Level 1	20 Minutes	Initial inpatient consultation for a new or established patient, which requires these three components: A problem focused history A problem focused examination Straightforward medical decision making Usually, the presenting problems are self limited or minor. Physicians typically spend 20 minutes at the bedside and on the patient's hospital floor or unit.
99252	Level 2	40 Minutes	Initial inpatient consultation for a new or established patient, which requires these three components: An expanded problem focused history An expanded problem focused examination Straightforward medical decision making Usually, the presenting problems are of low severity. Physicians typically spend 40 minutes at the bedside and on the patient's hospital floor or unit.
99253	Level 3	55 Minutes	Initial inpatient consultation for a new or established patient, which requires these three components: A detailed history A detailed examination Medical decision making of low complexity Usually, the presenting problems are of moderate severity. Physicians typically spend 55 minutes at the bedside and on the patient's hospital floor or unit.
99254	Level 4	80 Minutes	Initial inpatient consultation for a new or established patient, which requires these three components: A comprehensive history A comprehensive examination Medical decision making of moderate complexity Usually, the presenting problems are of moderate to high severity. Physicians typically spend 80 minutes at the bedside and on the patient's hospital floor or unit.

99255	Level 5	110 Minutes	Initial inpatient consultation for a new or established patient, which requires these three components: A comprehensive history A comprehensive examination Medical decision making of high complexity Usually, the presenting problems are of moderate to high severity. Physicians typically spend 110 minutes at the bedside and on the patient's hospital floor or unit.
FOLLOW-UP INPATIENT CONSULTATIONS			
Established Patients			
99261	Level 1	10 Minutes	Follow-up inpatient consultation for an established patient, which requires at least two of these three components A problem focused interval history A problem focused examination Medical decision making that is straightforward or of low complexity Usually the patient is stable, recovering or improving. Physicians typically spend 10 minutes at the bedside and on the patient's floor or unit.
99262	Level 2	20 Minutes	Follow-up inpatient consultation for an established patient, which requires at least two of these three components An expanded problem focused interval history An expanded problem focused examination Medical decision making of moderate complexity Usually the patient is responding inadequately to therapy or has developed a minor complication. Physicians typically spend 20 minutes at the bedside and on the patient's floor or unit.
99263	Level 3	30 Minutes	Follow-up inpatient consultation for an established patient, which requires at least two of these three components A detailed interval history A detailed examination Medical decision making of high complexity Usually the patient is unstable or has developed a significant complication or a significant new problem. Physicians typically spend 30 minutes at the bedside and on the patient's floor or unit.

EMERGENCY DEPARTMENT SERVICES			
99281	Level 1	Session	Emergency Department visit for the evaluation and management of a patient which requires these three key components: A problem focused history A problem focused examination Straightforward medical decision making Usually the presenting problems are self limited or minor.
99282	Level 2	Session	Emergency Department visit for the evaluation and management of a patient which requires these three key components: An expanded problem focused history An expanded problem focused examination Medical decision making of low complexity Usually the presenting problems are of low to moderate severity
99283	Level 3	Session	Emergency Department visit for the evaluation and management of a patient which requires these three key components: An expanded problem focused history An expanded problem focused examination Medical decision making of moderate complexity Usually the presenting problems are of moderate severity.
99284	Level 4	Session	Emergency Department visit for the evaluation and management of a patient which requires these three key components: A detailed history A detailed examination Medical decision making of moderate complexity Usually the presenting problems are of high severity, and require urgent evaluation by the physician but do not pose an immediate significant threat to life or physiologic function.
99285	Level 5	Session	Emergency Department visit for the evaluation and management of a patient which requires these three key components within the constraints imposed by the urgency of the patient's clinical condition and/or mental status. A comprehensive history A comprehensive examination Medical decision making of high complexity Usually the presenting problems are of high severity, and pose an immediate significant threat to life or physiologic function.
COMPREHENSIVE NURSING FACILITY ASSESSMENTS			
New or Established Patients			
99304	Initial Nursing Facility Care –Low Complexity	Per Day	**Initial nursing facility care, per day, for the evaluation and management of a patient which requires these three key components:** **A detailed or comprehensive history;** **A detailed or comprehensive examination and** **A medical decision making that is straightforward or of low complexity.** **Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.** **Usually, the problem(s) requiring admission are of low severity.**
99305	Initial Nursing Facility Care –Moderate Complexity	Per Day	**Initial nursing facility care, per day, for the evaluation and management of a patient which requires these three key components:** **A comprehensive history;** **A comprehensive examination and** **A medical decision making of moderate complexity.** **Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.** **Usually, the problem(s) requiring admission are of moderate severity.**
99306	Initial Nursing Facility Care –High Complexity	Per Day	**Initial nursing facility care, per day, for the evaluation and management of a patient which requires these three key components:** **A comprehensive history;** **A comprehensive examination and** **A medical decision making of high complexity.** **Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.** **Usually, the problem(s) requiring admission are of high severity.**

SUBSEQUENT NURSING FACILITY CARE			
99307	Subsequent Nursing Facility Care	Per Day	**Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least two of these three key components.** **A problem focused interval history;** **A problem focused examination;** **A straightforward medical decision making** **Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.** **Usually, the patient is stable, recovering, or improving.**
99308	Subsequent Nursing Facility Care	Per Day	**Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least two of these three key components.** **An expanded problem focused interval history;** **An expanded problem focused examination;** **Medical decision making of low complexity** **Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.** **Usually, the patient is responding inadequately to therapy or has developed a minor complication.**
99309	Subsequent Nursing Facility Care	Per Day	**Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least two of these three key components.** **A detailed interval history;** **A detailed examination;** **Medical decision making of moderate complexity** **Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.** **Usually, the patient has developed a significant complication or a significant new problem.**
99310	Subsequent Nursing Facility Care	Per Day	**Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least two of these three key components.** **A comprehensive interval history;** **A comprehensive examination;** **Medical decision making of high complexity** **Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.** **The patient may be unstable or may have developed a significant new problem requiring immediate physician attention.**
99318	Other Nursing Facility Services	Per Visit	**Evaluation and management of a patient involving annual nursing facility assessment, which requires these three key components.** **A detailed interval history;** **A comprehensive examination;** **Medical decision making that is of low to moderate complexity.** **Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.** **Usually, the patient is stable, recovering, or improving.** **(Do not report 99318 on the same date of services as nursing facility services codes 99304-99316)**

DOMICILIARY, REST HOME (e.g., Boarding Home) OR CUSTODIAL CARE SERVICES			
New Patient			
99324	**Domiciliary or Rest Home Visit – Low Severity New Patient**	Per Visit	**Domiciliary or rest home visit for the evaluation and management of a new patient which requires these three key components: A problem focused history; A problem focused examination; and A straightforward medical decision making Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low severity. Physicians typically spend 20 minutes with the patient and/or family or caregiver.**
99325	**Domiciliary or Rest Home Visit – Moderate Severity New Patient**	Per Visit	**Domiciliary or rest home visit for the evaluation and management of a new patient which requires these three key components: An expanded problem focused history; An expanded problem focused examination; and Medical decision making of low complexity Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Physicians typically spend 30 minutes with the patient and/or family or caregiver.**
99326	**Domiciliary or Rest Home Visit – Moderae to High Severity New Patient**	Per Visit	**Domiciliary or rest home visit for the evaluation and management of a new patient which requires these three key components: A detailed history; A detailed examination; and Medical decision making of moderate complexity Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 45 minutes with the patient and/or family or caregiver.**
99327	**Domiciliary or Rest Home Visit – High Severity New Patient**	Per Visit	**Domiciliary or rest home visit for the evaluation and management of a new patient which requires these three key components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate complexity Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity. Physicians typically spend 60 minutes with the patient and/or family or caregiver.**
99328	**Domiciliary or Rest Home Visit – Significant New Problem Requiring Immediate Physician Attention New Patient**	Per Visit	**Domiciliary or rest home visit for the evaluation and management of a new patient which requires these three key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is unstable or has developed a significant new problem requiring immediate physician attention. Physicians typically spend 75 minutes with the patient and/or family or caregiver.**

Established Patient			
99334	**Domiciliary or Rest Home Visit – Minor Established Patient**	Per Visit	**Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least two of these three key components.** **A problem focused interval history;** **A problem focused examination;** **A straightforward medical decision making** **Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.** **Usually the presenting problem(s) are self-limited or minor. Physicians typically spend 15 minutes with the patient and/or family or caregiver**
99335	**Domiciliary or Rest Home Visit – Low to Moderate Severity Established Patient**	Per Visit	**Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least two of these three key components.** **An expanded problem focused interval history;** **An expanded problem focused examination;** **Medical decision making of low complexity** **Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.** **Usually the presenting problem(s) are of low to moderate severity. Physicians typically spend 25 minutes with the patient and/or family or caregiver.**
99336	**Domiciliary or Rest Home Visit – Moderate to High Severity Established Patient**	Per Visit	**Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least two of these three key components.** **An detailed interval history;** **An detailed examination;** **Medical decision making of moderate complexity** **Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.** **Usually the presenting problem(s) are of moderate to high severity. Physicians typically spend 40 minutes with the patient and/or family or caregiver.**
99337	**Domiciliary or Rest Home Visit – Significant New Problem Requiring Immediate Physician Attention Established Patient**	Per Visit	**Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least two of these three key components.** **An comprehensive interval history;** **An comprehensive examination;** **Medical decision making of moderate to high complexity** **Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.** **Usually the presenting problem(s) are of moderate to high severity. The patient may be unstable or may have developed a significant new problem requiring immediate physician attention. Physicians typically spend 60 minutes with the patient and/or family or caregiver.**
PATHOLOGY & LABORATORY			
Organ or Disease Oriented Panels			
80050	General Health Panel	Session	This panel must now include the following: Comprehensive metabolic panel (80053), Blood count, complete (CBC), automated and automated differential WBC count (85025 or 85027 and 85004) OR Blood count, complete (CBC) automated (85027) and appropriate manual differential WBC count (85007 or 85009), Thyroid stimulating hormone (TSH) (84443).
S3645	HIV-1 Antibody Testing	Session	HIV-1 antibody testing of oral mucosal transudate.
DRUG TESTING			
80100	Drug Screen, qualitative	Session	Drug screen, qualitative; multiple drug classes chromatographic method, each procedure.

80101	Drug Screen, single	Session	Single drug class method (e.g., immunoassay, enzyme assay), each drug class.
80102	Drug Confirmation	Per Procedure	Use 80100 for each multiple drug class chromatographic procedure. Use 80102 for each procedure necessary for confirmation. For chromatography, each combination of stationary and mobile phase is to be counted as one procedure. For example, if detection of three drugs by chromatograph requires one stationary phase with three mobile phases, use 80100 three (3) times. However, if multiple drugs can be detected using a single analysis (e.g., one stationary phase with one mobile phase), use 80100 only once.
80103	Tissue Preparation for Drug Analysis	Per Procedure	Tissue preparation for drug analysis.
URINALYSIS			
81002	Urinalysis without microscopy	Session	Non-automated, without microscopy
	Urinalysis	Session	Lab, urinalysis; qualitative or seminquantitative, except immunoassays.
81025	Pregnancy Test	Session	Urine pregnancy test, by visual color comparison methods.
CHEMISTRY			
82055	Alcohol (ethanol); Any specimen except breath	Per Procedure	Alcohol (ethanol); any specimen except breath.
82075	Breath Alcohol	Session	Alcohol – Breath
82270	Blood Occult	Each	Blood, occult, by peroxidase activity (e.g., guaiac), qualitative; feces, . **consecutive collected specimens with single determination, for colorectal neoplasm screening (ie, patient was provided three cards or single triple card for consecutive collection)**
82271	Other Sources	Each	Other Sources
82272	Blood Occult	Each	**Blood, occult by peroxidase activity (eg, guaiac). Qualitative, feces, single specimen (eg, from digital rectal exam)**
82800	Gases, Blood	Session	Gases, Blood, pH only
IMMUNOLOGY			
86580	TB intradermal	Session	Tuberculosis, intradermal
HEMATOLOGY AND COAGULATION			
85025	Complete (CBC) automated	Per Procedure	Complete (CBC) automated (Hgb, Hct, RBC, WBC, and platelet count) automated differential WBC count.
85027	Hemogram automated	Session	Hemogram and platelet count, automated
85048	Leukocyte, (WBC),automated	Session	Leukocyte White Blood Cell (WBC), automated.
VENOUS			
36415	Venipuncture	Session	Collection of venous blood by venipuncture
36416	Collection of Capillary Blood Specimen	Per Procedure	Collection of capillary blood specimen (e.g., finger, heel, ear stick).
82948	Blood, reagent strip	Per Procedure	Blood, reagent strip
THERAPEUTIC, PROPHYLACTIC OR DIAGNOSTIC INJECTIONS			
90772	Injection	Each	**Therapeutic, prophylactic or diagnostic injection (specify substance or drug); subcutaneous or intramuscular.**

CARDIOGRAPHY			
93005	ECG without interpretation and report	Session	ECG Tracing only, without interpretation and report
93010	ECG report interpretation	Session	ECG, Interpretation and report only
NEUROLOGICAL			
95816	EEG	20-40 Minutes	Electroencephalogram (EEG) including recording awake and drowsy (including hyperventilation and/or photic stimulation when appropriate).
PHYSICAL MEDICINE AND REHABILITATION			
97110	Therapeutic Procedure	15 minutes	Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility.
97530	Therapeutic Activities	15 Minutes	Therapeutic activities, direct (one-on-one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes.
97532	Cognitive Skills Development	15 Minutes	Development of cognitive skills to improve attention, memory, problem solving, (including compensatory training), direct (one-on-one) patient contact by the provider, each 15 minutes
97533	Sensory Integrative Techniques	15 Minutes	Sensory Integrative techniques to enhance sensory processing and promote adaptive responses to environmental demands, direct (one-on-one) patient contact by the provider, each 15 minutes.
97535	Self Care training each 15 minutes	15 Minutes	Self care/home management training (e.g., activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instruction in use of assistive technology devises/adaptive equipment) direct one on one contact by provider, each 15 minutes
97537	Community/work reintegration training each 15 minutes	15 Minutes	Community/work reintegration training (e.g. shopping, transportation, money management, vocational activities and/or work environment/modification analysis, work task analysis, use of assistive technology device/adaptive equipment), direct one-on-one contact by provider, each 15 minutes.
OTHER PROCEDURES			
97003	Occupational Therapy Assessment	Session	Selectively includes the administrative of cognitive screening, perceptual tests and/or developmental tests. Provided by a certified occupational therapist or designated occupational therapy trainee supervised by a certified occupational therapist.
97004	Occupational Therapy Re-Evaluation	Session	Re-evaluation with recommendation for resident placement, supervision, and/or care based on the patient's level of functioning.
S0302	Early Periodic Screening	Session	Completed early periodic screening diagnosis and treatment (EPSDT) service (List in addition to code for appropriate evaluation and management service).
SPECIAL SERVICES PROCEDURES AND REPORTS			

97802	Medical Nutrition Therapy	15 Minutes	Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with patient, each 15 minutes.
99000	Handling of specimen for transfer	Session	Handling and/or conveyance of specimen for transfer from the physician's office to a laboratory
99075	Medical testimony	Session	Medical Testimony
99078	Educational services by physician in a group setting	Session	Physician educational services rendered to patients in a group setting (e.g., prenatal, obesity, diabetic, or instructions) For counseling groups of clients with symptoms or established illness, e.g., CD education groups.
S9445	Patient Education, Individual	Session	Patient education, not otherwise classified, non-physician provider, individual, per session.
S9446	Patient Education, Group	Session	Patient education, not otherwise classified, non-physician provider, group, per session.
99080	Special Reports / Forms	Session	Special reports such as insurance forms, more than the information conveyed in the usual medical communications or standard reporting form
HCPCS CODES			
S9529	Routine Venipuncture	Session	Routine venipuncture for collection of specimen(s), single home bound, nursing home, or skilled nursing facility patient.
G0129	Occupational Therapy	Per Day	Occupational therapy requiring the skills of a qualified occupational therapist, furnished as a component of a partial hospitalization treatment program, per day
G0155	Social Worker, Home Health Setting	15 Minutes	Services of clinical social worker in home health setting, each 15 minutes
G0176	Activity Therapy	Session	Activity therapy such as music, dance, art or play therapies not for recreation, related to the care and treatment of patient's disabling mental health problems. 45 minutes or more = session.
G0177	Training and Education	Session	Training and education services related to the care and treatment of patient's disabling mental health problems. 45 minutes or more = session.
J0515	Cogentin per 1 mg	Session	Cogentin, Benztropin mesylate per 1 mg.
J1200	Benadryl up to 50 mg	Session	Benadryl, Diphenhydramine HCl up to 50 mg.
J1630	Haldol up to 5 mg	Session	Haldol, Haloperidol up to 5 mg.
J1631	Haldol per 50 mg	Session	Haldol, Haloperidol per 50 mg.
J2680	Prolixin up to 25 mg	Session	Prolixin Fluphenazine decanoate Prolixin, up to 25 mg.
J2794	Risperidone Injection	Each	Injection, risperidone, long acting, 0.5 mg.
J3490	Unclassified Drugs	Each Dispensing	Unclassified drugs.
M0064	Office visit for sole purpose of monitoring drugs	Session	Brief office visit for the sole purpose of monitoring or changing drug prescriptions used in the treatment of mental psychoneurotic and personality disorders
S0136	Clozapine	Each Dispensing	Clozapine, 25 mg., each dispensing.
S5000	Prescription Drug, Generic	Each Dispensing	Prescription drug, generic.
S5001	Prescription Drug, Brand Name	Each Dispensing	Prescription drug, brand name.
S9075	Smoking Cessation Treatment	Session	Smoking cessation treatment.
S9453	Smoking Cessation Classes	Session	Smoking cessation classes, non physician provider, per session
S9454	Stress Management	Session	Stress management classes, non-physician provider, per session
G9016	Smoking Cessation Individual Counseling	Session	Smoking cessation counseling, individual, in the absence of or in addition to any other evaluation and management services, per session (6-10 minutes)
H1010	Non-Medical Family Planning Education	Per Session	Non-Medical Family Planning Education, per session.
H1011	Family Assessment	Per Session	Family assessment by licensed behavioral health professional for state defined purposes.
H2010	Comprehensive Medication Services	15 Minutes	Comprehensive Medication Service, per 15 minutes.
H2011	Crisis Intervention Services	15 Minutes	Crisis Intervention Service, per 15 minutes
H2012	Behavioral Health Day Treatment	Per Hour	Behavioral Health Day Treatment, per hour
H2013	Psychiatric Health Facility	Per Diem	Psychiatric health facility services per diem.
H2014	Skills Training and Development	15 Minutes	Skills training and development, per 15 minutes
H2015	Community Support Services	15 Minutes	Comprehensive community support services, per 15 minutes
H2016	Community Support Services	Per Diem	Comprehensive community support services, per diem
H2017	Psychosocial Rehabilitation Services	15 Minutes	Psychosocial rehabilitation services, per 15 minutes.
H2018	Psychosocial Rehabilitation Services	Per Diem	Psychosocial rehabilitation services, per diem.
H2019	Therapeutic Behavioral Services	15 Minutes	Therapeutic behavioral services, per 15 minutes.
H2020	Therapeutic Behavioral Services	Per Diem	Therapeutic behavioral services, per diem.
H2021	Community Based Wrap-Around	15 Minutes	Community based wrap around services, per 15 minutes
H2022	Community Based Wrap-Around	Per Diem	Community based wrap around services, per diem
H2023	Supported Employment	15 Minutes	Supported Employment, per 15 minutes
H2024	Supported Employment	Per Diem	Supported Employment, per diem
H2025	Ongoing Support for Employment	15 Minutes	Ongoing support to maintain employment, per 15 minutes
H2026	Ongoing Support for Employment	Per Diem	Ongoing support to maintain employment, per diem.
H2027	Psychoeducational Services	15 Minutes	Psychoeducation Services, per 15 minutes
H2028	Sexual Offender Treatment Services	15 Minutes	Sexual Offender Treatment Services, per 15 minutes
H2029	Sexual Offender Treatment Service	Per Diem	Sexual Offender Treatment Service, per diem
H2030	Mental Health Clubhouse	15 Minutes	Mental Health Clubhouse Services, per 15 minutes
H2031	Mental Health Clubhouse	Per Diem	Mental Health Clubhouse Services, per diem
H2032	Activity Therapy	15 Minutes	Activity therapy, per 15 minutes
H2033	Multisystemic Therapy – Juveniles	15 Minutes	Multisystemic Therapy for juveniles, per 15 minutes
H2034	Alcohol and/or Drug Abuse Halfway House	Per Diem	Alcohol and/or Drug Abuse Halfway House Services, Per Diem
H2035	Alcohol and/or Other Drug Treatment Program	Per Hour	Alcohol and/or Other Drug Treatment Program, per hour
H2036	Alcohol and/or Other Drug Treatment Program, per diem	Per Diem	Alcohol and/or Other Drug Treatment Program, per diem
H2037	Developmental Delay Prevention Activities	15 Minutes	Developmental delay prevention activities, dependent child of client.

ALCOHOL AND DRUG TREATMENT SERVICES			
H0001	Assessment	Session	Alcohol and/or drug assessment
H0002	Eligibility Screening	Session	Behavioral health screening to determine eligibility for admission to treatment program
T2010	PASRR – Level I	Per Screen	Preadmission Screening and Resident Review (PASRR) Level I identification Screening, per screen.
T2011	PASRR – Level II	Per Evaluation	Preadmission Screening and Resident Review (PASRR) Level II Evaluation, per evaluation.
T2012	Habilitation, Educational	Per Diem	Habilitation, educational; waiver, per diem
T2013	Habilitation, Educational	Per Hour	Habilitation, educational, waiver, per hour
T2014	Habilitation, Pre-vocational	Per Diem	Habilitation, prevocational, waiver; per diem
T2015	Habilitation, Pre-vocational	Per Hour	Habilitation, prevocational, waiver; per hour
T2016	Habilitation, Residential	Per Diem	Habilitation, residential, waiver; per diem
T2017	Habilitation, Residential	15 Minutes	Habilitation, residential, waiver, 15 minutes
T2018	Habilitation, Supported Employment	Per Diem	Habilitation, supported employment, waiver, per diem
T2019	Habilitation, Supported Employment	15 Minutes	Habilitation, supported employment, waiver, per 15 minutes
T2020	Day Habilitation	Per Diem	Day habilitation, waiver; per diem
T2021	Day Habilitation	15 Minutes	Day habilitation, waiver; per 15 minutes
T2022	Case Management	Per Month	Case Management, per month
T2023	Target Case Management	Per Month	Targeted case management; per month
H0003	Laboratory Analysis	Session	Alcohol and/or drug screening; laboratory analysis of specimens for presence of alcohol and/or drugs
H0004	Counseling And Therapy	15 Minutes	Behavioral health counseling and therapy, per 15 minutes
H0005	Group Counseling	Session	Alcohol and/or drug services; group counseling by a clinician
H0006	Case Management	Session	Alcohol and/or drug services; case management
H0007	Outpatient Crisis Intervention	Session	Alcohol and/or drug services; crisis intervention (outpatient)
H0008	Inpatient Sub-Acute Detoxification	Session	Alcohol and/or drug services; sub-acute detoxification (hospital inpatient)
H0009	Inpatient Acute Detoxification	Session	Alcohol and/or drug services; acute detoxification (hospital inpatient)
H0010	Residential Inpatient Sub-Acute Detoxification	Session	Alcohol and/or drug services; sub-acute detoxification (residential addiction program inpatient)
H0011	Residential Inpatient Acute Detoxification	Session	Alcohol and/or drug services; acute detoxification (residential addiction program inpatient)
H0012	Residential Outpatient Sub-Acute Detoxification	Session	Alcohol and/or drug services; sub-acute detoxification (residential addiction program outpatient)
H0013	Residential Outpatient Acute Detoxification	Session	Alcohol and/or drug services; acute detoxification (residential addiction program outpatient)
H0014	Ambulatory detoxification	Session	Alcohol and/or drug services; ambulatory detoxification
S9475	Ambulatory Setting	Session	Ambulatory setting substance abuse treatment or detoxification services, per diem
H0015	Intensive Outpatient Treatment Program	Session	Alcohol and/or drug services; intensive outpatient (treatment program that operates at least 3 hours/day and at least 3 days/week and is based on an individualized treatment plan), including assessment, counseling; crisis intervention, and activity therapies or education.
H0016	Medical/Somatic	Session	Alcohol and/or drug services; medical/somatic (medical intervention in ambulatory setting)
H0017	Residential – Hospital	Session	Behavioral health; residential hospital treatment program), without room and board, per diem.
H0018	Non-Hospital Residential	Session	Behavioral health; short term residential (non-hospital residential treatment program), without room and board, per diem
H0019	Long-Term Residential	Session	Behavioral health; long-term residential (non-medial, non-acute care in a residential treatment program where stay is typically longer than 30 days), without room and board, per diem
H0020	Methadone Administration	Session	Alcohol and/or drug services; methadone administration and/or service (provision of the drug by a licensed program)
H0021	Training Services	Session	Alcohol and/or drug training service (for staff and personnel not employed by providers)
H0022	Intervention Services	Session	Alcohol and/or drug intervention services (planned facilitation)
H0023	Drug Outreach Service	Session	Behavioral health outreach service (planned approach to reach a target population).
H0024	Prevention Information Dissemination Service	Session	Behavioral health prevention information dissemination service (one-way direct or non-direct contact with service audiences to affect knowledge and attitude).
H0025	Prevention Education Service	Session	Behavioral health prevention education service (delivery of services with target population to affect knowledge, attitude and/or behavior)
H0026	Prevention Process Service	Session	Alcohol and/or drug prevention process services, community-based (delivery of services to develop skills of impactors)
H0027	Prevention Environmental Services	Session	Alcohol and/or drug prevention environment service (broad range of external activities geared toward modifying systems in order to mainstream prevention through policy and law)
H0028	Prevention Problem Identification and Referral Service	Session	Alcohol and/or drug prevention program identification and referral services (e.g., student assistance and employee assistance programs), does not include assessment
H0029	Prevention Alternative Services	Session	Alcohol and/or drug prevention alternatives services (services for populations that exclude alcohol and other drug use e.g., alcohol free social events)
H0030	Hotline Services	Session	Behavioral health hotline service
H0031	Mental Health Assessment	Session	Mental health assessment, by non-physician
H0032	Mental Health Service Plan	Session	Mental health service plan development by non-physician
H0033	Oral Medication Administration	Each Dispensing	Oral medication administration, direct observation
H0034	Medication Training and Support	15 minutes	Medication training and support, per 15 minutes
H0035	Mental Health Partial Hospitalization	Less than 24 hours	Mental Health partial hospitalization, treatment, less than 24 hours

S0201	Partial Hospitalization Services	Per Diem	Partial hospitalization services, less than 24 hours, per diem
H0036	Community Psychiatric Supportive Treatment	15 minutes	Community psychiatric supportive treatment, face-to-face, per 15 minutes
H0037	Community Psychiatric Supportive Treatment Program	Per Diem	Community psychiatric supportive treatment program, per diem
H0038	Self-help/Peer services	15 minutes	Self-help/peer services, per 15 minutes
H0039	Assertive Community Treatment	15 minutes	Assertive community treatment, face-to-face, per 15 minutes
H0040	Assertive Community Treatment	Per Diem	Assertive community treatment program, per diem
H0041	Foster Care, Child, Non- therapeutic	Per Diem	Foster care, child, non-therapeutic, per diem
H0042	Foster Care, Child, Non-therapeutic	Per Month	Foster care, child, non-therapeutic, per month
H0043	Supported Housing	Per Diem	Supported Housing, per diem
H0044	Supported Housing	Per Month	Supported Housing, per month
H0045	Respite Care Services, Not in Home	Per Diem	Respite care services, not in the home, per diem
H0046	Mental Health Services	Session	Mental health services, not otherwise specific
H0047	Alcohol and/or other drug abuse services	Session	Alcohol and/or other drug abuse services, not otherwise specified
H0048	Alcohol and/or other drug testing	Session	Alcohol and/or other drug testing: collection and handling only, specimens other than blood
H0049	Alcohol and/or other drug screening	Session	Alcohol and/or other drug screening
H0050	Alcohol and/or other drug service, brief intervention, per 15 minutes	15 minutes	Alcohol and/or other drug service, brief intervention, per 15 minutes

MRO CODES AND "T" CODES ESTABLISHED FOR STATE MEDICAID AGENCY

T1001	Nursing Assessment/Evaluation	Session	Nursing assessment/evaluation.
T1002	RN Services	15 Minutes	RN services, up to 15 minutes.
T1003	LPN/LVN Services	15 Minutes	LPN/LVN services, up to 15 minutes.
T1004	Nursing Aide	15 Minutes	Services of a qualified nursing aide, up to 15 minutes.
T1005	Respite Care	15 Minutes	Respite care services, up to 15 minutes.
T1006	Alcohol/Substance Abuse Services Counseling	Session	Alcohol and/or substance abuse services, family/couple counseling.
T1007	Alcohol/Substance Abuse Services Treatment Plan	Session	Alcohol and/or substance abuse services, treatment plan development and/or modification.
T1009	Alcohol/Substance Abuse Child Sitting Services	Session	Child sitting services for children of the individual receiving alcohol and/or substance abuse services.
T1010	Alcohol/Substance Abuse Meals	Session	Meals for individuals receiving alcohol and/or substance abuse services (when meals not included in the program).
T1012	Alcohol/Substance Abuse Skills Development	Session	Alcohol and/or substance abuse services, skills development.
T1013	Sign Language/Interpreter	15 Minutes	Sign language or oral interpreter services, per 15 minutes
T1014	Telehealth Transmission	Per Minute	Telehealth transmission, per minute, professional services bill separately.
T1015	Clinic Visit/Encounter	Session	Clinic visit/encounter, all-inclusive
T1016	Case Management	15 Minutes	Case management, each 15 minutes
T1017	Targeted Case Management	15 Minutes	Targeted case management, each 15 minutes
T1025	Intensive, Extended Multidisciplinary Services	Per Diem	Intensive extended multidisciplinary services provided in a clinic setting to children with complex medical, physical, mental and psychosocial impairments, per diem.
T1026	Intensive, Extended Multidisciplinary Services	60 Minutes	Intensive, extended multidisciplinary services provided in a clinic setting to children with complex medical, physical, mental and psychosocial impairments, per hour
T1027	Family Training and Counseling for Child Development	15 Minutes	Family training and counseling for child development, per 15 minutes.
T1028	Assessment of Home, Physical and Family Environment		Assessment of home, physical and family environment, to determine suitability to meet patient's medical needs, per session.
TRANSPORTATION			
S0207	Paramedic Intercept	Session	Paramedic intercept, non-hospital-based ALS service (non-voluntary), non-transport.
S0208	Paramedic Intercept	Session	Paramedic intercept, hospital based ALS service (non-voluntary), non-transport.
S0209	Wheelchair Van	Per Mile	Wheelchair van, mileage, per mile.
S0215	Non-Emergency Transportation	Per Mile	Non-emergency transportation; mileage.
T2001	Non-emergency Transportation	Trip	Non-Emergency transportation; patient attendant/escort
T2002	Non-emergency Transportation	Per Diem	Non-emergency transportation; per diem
T2003	Non-emergency Transportation	Trip	Non-emergency transportation; encounter/trip
T2004	Non-emergency Transportation	Trip	Non-emergency transport; commercial carrier, multi-pass
T2005	Non-emergency Transportation	Trip	Non-emergency transportation; stretcher van
PATIENT SERVICES			
S5100	Day Care Services – Adult	15 Minutes	Day care services, adult, per 15 minutes
S5101	Day Care Services – Adult	Per Half Day	Day care services, adult, per half day
S5102	Day Care Services – Adult	Per Diem	Day care services, adult, per diem
S5105	Day Care Services / Center-based	Per Diem	Day care services, center-based, services not included in program fee, per diem.
S5140	Foster Care – Adult	Per Diem	Foster care, adult per diem
S5141	Foster Care – Adult	Per Month	Foster care, adult per month
S5145	Foster Care – Therapeutic – Child	Per Diem	Foster care, therapeutic, child; per diem
S5146	Foster Care, Therapeutic – Child	Per Month	Foster care, therapeutic, child, per month
S5150	Unskilled Respite Care	15 Minutes	Unskilled respite care, not hospice, per 15 minutes
S5151	Unskilled Respite Care	Per Diem	Unskilled respite care, not hospice, per diem.
S9484	Crisis Intervention Mental Health Services	Per hour	Crisis intervention mental health services, per hour
S9485	Crisis Intervention Mental Health Services	Per Diem	Crisis intervention mental health services, per diem
S9127	Social Work Visit	Session	Social work visit, in the home, per diem.
RESPITE CARE (Therapeutic Intervention)			

S9125	Respite Care	Session	Respite Care, in the home, per diem.
UB FACILITY CODES			
124	Psychiatric Room	24 Hours	Room and board - semi private – psychiatric
126	Detox	24 Hours	Room and board – semi private – 2 bed Detoxification
250	Pharmaceuticals	$1.00	Dispensing of medications including the cost of pharmaceuticals.
270	Medical/Surgical Supplies	Session	Charges for supply items required for patient care.
300	Lab	Session	Laboratory – General classification
320	Radiology	Session	Radiology – Diagnostic – General Classification
410	Respiratory Services	Session	Administration of oxygen and certain potent drugs through inhalation or positive pressure and other forms of rehabilitative therapy through measurement of inhaled and exhaled gases and analysis of blood and evaluation of patient's ability to exchange oxygen and other gases.
430	Occupational Therapy	Session	Services provided by a qualified occupational therapy practitioner for therapeutic interventions to improve, sustain, or restore an individual's level of function in performance of activities of daily living and work, including: therapeutic activities, therapeutic exercises; sensorimotor processing; psychosocial skills training; cognitive retraining; fabrication and application of orthotic devices; and training in the use of orthotic and prosethic devices; adaptation of environments; and application of physical agent modalities.
450	Emergency Room	Session	Charges for emergency treatment to those ill and injured persons who require immediate unscheduled medical or surgical care.
560	Medical Social Services	Session	Charges for services such as counseling patients interviewing patients, and interpreting problems of a social situation rendered to patients on any basis.
710	Recovery Room	Session	
730	EKG/ECG	Session	Charges for operation of specialized equipment to record electromotive variations in actions of the heart muscle on an electrocardiograph for diagnosis of heart ailments.
762	Intensive Observation	Days	Treatment/Observation Room – Intensive
900	Psychiatric/Psychological	Session	Code includes electroshock treatment, milieu therapy, play therapy and activity therapy.
910	Psychiatric/Psychological Services	Session	Indicates charges for providing nursing care and professional services for emotionally disturbed patients. Includes individual therapy, group therapy, family therapy, testing, rehabilitation and partial hospitalization.
941	Recreational Therapy	Session	

ATTACHMENT B

FUNDING, MONTHLY CLOSE-OUT, AND BILLING INFORMATION

FUNDING

Carve-Out Funding: Funding and payments will be made, per consumer registration, for the following populations:

Population "Carve-Out"	SFY 2008 Rate Per Consumer
Assertive Community Treatment (ACT)	$5,330
Deaf Seriously Mentally Ill (DMI)	$4,500
Deaf Seriously Emotionally Disturbed (DED)	$4,500
Deaf Gambling (DGM)	$4,500
Deaf Chronic Addiction (DCA)	$4,500
Gambling (GAM)	$2,204
Methadone (SMO)	$2,250
State Operated Facility (SOF)	$18,220
Special (SPL)	$18,220

Outcome Criteria Funding: Funding for Seriously Mentally Ill (SMI) Outcome Measures, Chronically Addicted (CA) Outcome Measures, and Seriously Emotionally Disturbed Children (SED) Outcome Measures will be available in CSDS on a quarterly basis. When dollars are added to CSDS, the provider will be notified, via email, that dollars are available. Typically, dollars will be added to CSDS the first full week of the quarter (July, October, January, and April). This is commonly referred to as Outcome Measures funding. Payment will be a per-quarter lump-sum payment.

Process Criteria Funding: Funding for Seriously Mentally Ill (SMI) Process Measures, Chronically Addicted (CA) Process Measures, and Seriously Emotionally Disturbed Children (SED) Process Measures will be available in CSDS three times during a state fiscal year – November, February, and May, as lump-sum payments. This funding mechanism is referred to as Process Measure funding. If dollars are added to CSDS for the Process Criteria funding, the provider will be notified, via email, that dollars are available in CSDS.

Bonus Pool: Based on provider contracted populations, each performance measure target will have a dollar amount allocated to it. Level of payment will be determined by the provider's performance toward meeting their targets. If the provider meets the established target, they will receive 100% of the dollars allocated toward that measure. If the performance is less than the established target, they will receive a reduced percentage of funds related to the level of performance. All allocated dollars not paid out due to under performance will be shifted to a bonus pool. When a provider exceeds 100% of a designated performance target they will be eligible for participation in receiving funds as available from a bonus pool. The bonus pool created from the process measures will be paid out during the last quarter of the year while the bonus pool for the outcome measures will be included in the next year's allocation for those providers who qualify.

MONTHLY VOUCHER SUMMARY / CLOSE OUT

At any point during the month, an agency may elect to closeout the month and create a Monthly Voucher Summary. If the agency elects to manually close out the month and create the Monthly Voucher Summary the agency will not be permitted to close out the next month until after the 20th of the month. If an agency does not elect to closeout the month, the CSDS will automatically "closeout" on the 20th of each month (beginning August 20) and create a Monthly Voucher Summary. Once a Monthly Voucher Summary is created it may not be changed or edited.

	FY 2008 Voucher Summary Periods	***CLOSEOUT DATES***
1.	July 2007	Before or on August 20, 2007
2.	August 2007	Before or on September 20, 2007
3.	September 2007	Before or on October 20, 2007
4.	October 2007	Before or on November 20, 2007
5.	November 2007	Before or on December 20, 2007
6.	December 2007	Before or on January 20, 2008
7.	January 2008	Before or on February 20, 2008
8.	February 2008	Before or on March 20, 2008
9.	March 2008	Before or on April 20, 2008
10.	April 2008	Before or on May 20, 2008
11.	May 2008	Before or on June 20, 2008
12.	June 2008	To be manually closed out by the Provider no later than August 10, 2008. The June, 2008 Voucher Summary will only contain funding through the Fiscal Year (June 30, 2008).

The agency will then electronically request payment through the CSDS Web-site for reimbursement, if the agency is claiming funds. Please remember that FSSA/DMHA can only reimburse (or make payments) to an agency if an approved/activated contract is on file for SFY 2008.

NOTE: Each Provider needs to keep in mind that reimbursement may only occur once a month, for a total of 12 per state fiscal year.

AGENCY BILLING PROCEDURES

CSDS allows Providers to request payment through the CSDS web-site. The Voucher Activity screen on CSDS is used for the requesting of payment or electronically submitting vouchers. A link from the Voucher List to the Voucher Activity screen provides the graphical interface to request payment.

A funding request is made after a voucher has been created using the standard CSDS close month process. Funding information is available on the Voucher Activity screen. The user navigates to the Voucher Activity screen via the Voucher List. After the user requests payment, it is approved by two DMHA staff members. Finally, the FSSA Claim Management System (CMS) will electronically submit the request to the State Auditor's Office so that the direct deposit will occur.

Please see the attachment to this section entitled *"Electronic Payment Request Overview"* for detailed instructions on how to request payment.

END OF THE STATE FISCAL YEAR INFORMATION

The June 2008 Monthly Voucher Summary will not have an automatic closeout date. It will be the responsibility of each Provider to manually close out their fiscal year and finalize the June 2008 Monthly Voucher Summary. The Provider should not closeout their June 2008 Monthly Voucher Summary until they know they have COMPLETED AND ARE READY TO CLOSE OUT THE FISCAL YEAR. If a Provider processes a June 2008 Monthly Voucher Summary prior to all Transactions being submitted requesting funds (including those rejected for critical errors corrected), the Provider will close out their Fiscal Year and may not receive payment for all enrollments.

Historically we have referred to the final dollar amount on your contract as a **partial rate** billing. The June Voucher Summaries will still denote one consumer for the final amount, per population, on the remaining dollars.

ELECTRONIC PAYMENT REQUEST OVERVIEW

Introduction

MCPs will request payments through CSDS to the FSSA Claims Management Office electronically by clicking a single button.

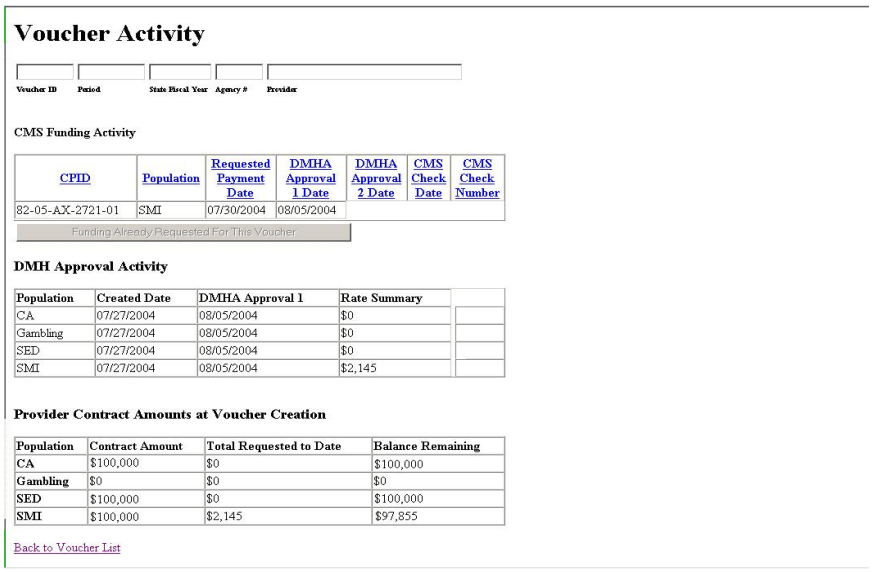
This portion of the document includes the procedures used to submit electronic vouchers utilizing the CSDS system.

Requesting Payment

The Voucher Activity screen is used for the requesting payment or electronically submitting vouchers. A link from the Voucher List to the voucher activity screen provides the graphical interface to request payment.

A funding request is made after a voucher has been created using the standard CSDS close month process. Funding information is available on the voucher activity screen. The user navigates to the voucher activity screen via the Voucher List. After the user requests payment, it is approved by two DMHA staff members. Finally, the FSSA Claim Management System (CMS) will electronically submit the request to the State Auditor's Office so that the reimbursement will occur (direct deposit).

The Voucher Activity screen provides an interface for payment processing information and requests. Below is a screenshot illustrating the Voucher Activity screen.



Voucher Activity

Voucher ID | Period | State Fiscal Year | Agency # | Provider

CMS Funding Activity

CPID	Population	Requested Payment Date	DMHA Approval 1 Date	DMHA Approval 2 Date	CMS Check Date	CMS Check Number
82-05-AX-2721-01	SMI	07/30/2004	08/05/2004			

Funding Already Requested For This Voucher

DMH Approval Activity

Population	Created Date	DMHA Approval 1	Rate Summary	
CA	07/27/2004	08/05/2004	$0	
Gambling	07/27/2004	08/05/2004	$0	
SED	07/27/2004	08/05/2004	$0	
SMI	07/27/2004	08/05/2004	$2,145	

Provider Contract Amounts at Voucher Creation

Population	Contract Amount	Total Requested to Date	Balance Remaining
CA	$100,000	$0	$100,000
Gambling	$0	$0	$0
SED	$100,000	$0	$100,000
SMI	$100,000	$2,145	$97,855

Back to Voucher List

The screen is divided into three sections. The first section is labeled “CMS Funding Activity” and provides an overview of the current state of a funding request. The second section label is “DMHA Approval Activity” and provides additional feedback about the approval process in the CSDS system. The third section title is “Provider Contract Amounts at Voucher Creation”. This is the data that is also present at the bottom of the voucher summary report. It is a point in time display of the contract amounts when the voucher was created.

The CMS Funding Activity columns are described below:

- CPID: Claim Program ID is the state assigned value linked to provider’s contract
- Requested Payment Date: Date the provider requested payment.
  - This value will be populated after clicking “Request Funding For This Voucher”
- DMHA Approval 1 Date: Date of first approval by DMHA staff.
  - This value is populated when a DMHA staff member releases the payment request from CSDS to the CMS system.
- DMHA Approval 2 Date: Date of second approval by DMHA staff.
  - This value is populated when a second DMHA staff member releases the payment request in the CMS system.
- CMS Check Date: Date the check is printed from CMS.
  - This value is populated with the date the check was printed in CMS.
- CMS Check Number: Check number of payment for request.

Payment can only be requested one time per voucher and should only be performed if the provider is certain they wish to submit the request to the DMHA. To request funding click the “Request Funding For This Voucher” button.

The CSDS Request Payment function is limited to those MCP staff members who have voucher creation authority. For questions or assistance, please contact Christi Hickman, CSDS Funding Specialist, at 317.232.7918 or Christi.Hickman@fssa.in.gov.